ASSOCIATION OF ALEXANDRIA RADIOLOGISTS

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4001 Prince William Parkway Suite 302, Woodbridge VA 22192

Alexandria Imaging Center / 703.751.5055 Phone
4660 Kenmore Avenue Suite 525, Alexandria VA 22304

HIPAA AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Association of Alexandria Radiologists PC (AAR) is committed to maintaining the privacy of your health information, and we abide by the terms of the **NOTICE OF PRIVACY PRACTICES** to guide how we may use and disclose your **Protected Health Information (PHI)** to carry out treatment, payment or health care operations, and for other purposes that are permitted or required by law.

You will be asked by AAR to sign a form stating that you have received the detailed NOTICE OF PRIVACY PRACTICES to help you better understand our policies in regard to PHI. Copies of this notice are available at our clinical offices, and online at AlexandriaRadiology.com.

In compliance with HIPAA's Privacy Rule, it is the policy of AAR to only allow properly-authorized individuals to have access to your PHI. Other uses and disclosures of your PHI will be made only when your written authorization is obtained and complies with the Health Insurance Portability and Accountability Act of 1996 (HIPAA) Privacy Standards.

I, (PRINT NAME) **_____,** (DOB) **____/____/____, authorize the release of my PHI as indicated below:**

□ Specific Exam(s)_____

□ All Exams

Types of Information:

□ Reports □ Images

□ Billing Information □ All Protected Health Information

Dates of Service:

□ Specific Date(s) _____/_____/_____ to _____/_____/_____

□ All future dates of service □ All previous and future dates of service

To the Individuals Listed Below:

NAME	ADDRESS	RELATIONSHIP

I understand that this authorization will remain in effect until revoked in writing by me, the patient. I understand that I have the right to revoke this authorization in writing by sending notification to: Association of Alexandria Radiologists, PC, 8001 Forbes Place, Suite 103, Springfield, VA 22151, Attention: Privacy Officer. I understand when I revoke this authorization, it is not effective to the extent that AAR has already relied on the use or disclose of the PHI. I also understand PHI released prior to this authorization may be re-disclosed by the party who received that information and may no longer be protected by federal or state law. AAR will not condition my treatment or payment on whether I provide an authorization for the requested use or disclosure.

_____ _____

Printed Patient Name Relationship to Patient

_____ _____

Signature of Patient or Legal Representative: Date

This form must be maintained with the medical record.