TOWER IMAGING
MEDICAL · GROUP
Imaging by Specialists

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Name: _____ Social Security # : _____-_____-_____

I request and authorize **TOWER IMAGING VALENCIA** to release healthcare information of the patient named above to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information

☐ Other: _____

MY RIGHTS

I understand I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment). However, I do have to sign an authorization form:

- To take part in research study or
- To receive healthcare when the purpose is to create healthcare information for a third party

I may revoke this authorization in writing. If I did, it would not affect any actions already taken by Tower Imaging Valencia Radiologists based on this authorization. I may not be able to revoke this authorization if its purpose was to obtain insurance. Two ways to revoke this authorization are:

- Fill out a revocation form. A form is available at Tower Imaging Valencia.
- Write a letter to Tower Imaging Valencia, attn: Jeanne Garcia.

Once healthcare information is disclosed, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

Patient Signature: _____ Date Signed: _____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED