

# Medical Thermography Associates

## Authorization to Use or Disclose Protected Health Information

Patient Name: \_\_\_\_\_

Address: \_\_\_\_\_

Date of Birth: \_\_\_\_\_ Date of Request: \_\_\_\_\_

**As required by the Privacy Regulations, Carolina Medical Thermography may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.**

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

### Physicians Insight, LLC

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail) **Interpretation of said images**

**Effective dates** for this authorization:

\_\_\_\_/\_\_\_\_/\_\_\_\_ (date of request) through \_\_\_\_/\_\_\_\_/\_\_\_\_ (5yrs from date of request)

This authorization will expire at the end of the above period.

I understand that if I authorize the information disclosed above to additional parties, the disclosed information may no longer be protected for reasons beyond our control.

**I understand I have the right to:**

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

\_\_\_\_\_  
*Signature or Patient or Patient's Authorized Representative*

\_\_\_\_\_  
*Date*

\_\_\_\_\_  
*Authorized Signature of Facility*

\_\_\_\_\_  
*Date*