SOUTH JERSEY RADIOLOGY ASSOCIATES

HIPAA Authorization

Patient Name: _____

Patient DOB: _____ Telephone Number: _____

☐ I hereby Authorize South Jersey Radiology Associates, to disclose/release my medical information *(Including, Reports, Images, Results and Financial Activity)* to:

_____ Relationship: _____
(Please Print) *(Please Print)*

_____ Relationship: _____
(Please Print) *(Please Print)*

_____ Relationship: _____
(Please Print) *(Please Print)*

SJRA will ask you to review your Authorization each year. This consent will remain in effect until revised or revoked by the Patient or Legal Guardian.

☐ I do not Authorize South Jersey Radiology Associates, to disclose/release my medical information *(Including, Reports, Images, Results and Financial Activity)* to:

_____
(Please Print)

_____
(Please Print)

PATIENT or Legal Guardian:_____
(Please Print Name)

X_____ _____
PATIENT or LEGAL GUARDIAN SIGNATURE Date

_____ _____
Witness Date