



# TEMPLETON IMAGING, Inc.

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## TEMPLETON IMAGING, INC.

*Board Certified Radiologists*

### PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

With my consent, TEMPLETON IMAGING, INC., may use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO). Please refer to TEMPLETON IMAGING, INC.'s Notice of Privacy Practices for a more complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices prior to signing this consent.

TEMPLETON IMAGING, INC. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to LINDA COSGROVE, PRIVACY OFFICER, c/o TEMPLETON IMAGING, INC. PO Box 489, Templeton, CA 93465 (805) 434-1491.

With my consent, TEMPLETON IMAGING, INC. may e-mail my home or other designated location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any call pertaining to my clinical care, including laboratory results among others.

With my consent, TEMPLETON IMAGING, INC. may mail and/or e-mail to my home or other designated location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

I have the right to request that TEMPLETON IMAGING, INC. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my request restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to TEMPLETON IMAGING, INC.'s use and disclosure of my PHI to carry out TPO. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign the consent, TEMPLETON IMAGING, INC. may decline to provide treatment to me.

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Signature of Patient or Legal Guardian

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Print Name of Patient or Legal Guardian

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Date