TEMPLETON IMAGING, Inc.
262 Posada Lane, Suite C, Templeton, CA 93465
(805) 434-1491 f: (805) 434-3591 | www.templetonimaging.com

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

Please fill out completely, sign, date and write your driver's license number on the last page of the form. You must complete one Authorization for each intended recipient. Once we receive your completed Authorization(s), our medical records staff will send you a copy of the records that you have requested. If you have any questions, please call the above phone number for assistance.

DATE: ______________________

I, ____

First **Middle** **Last**

Address: ______________________________**City/State/Zip:** ________________________________

Date of Birth ____________________________ **Phone #:**____________________________________

Specifically authorize the use and/or disclosure of the category of highly confidential information indicated next to the box below :

☐ **Report Only** ☐ **Film or Disc**

Date(s) of Treatment: ____

NAME OF PERSON RECEIVING INFORMATION: (separate request for each receiving party)
Name: _________________________________ **Phone #:** _____________________________________

Address: ______________________________**City/State/Zip:** ________________________________

PURPOSE:

☐ **Personal** ☐ **New Physician** ☐ **Primary Care Physician** ☐ **Social Security Disability**

☐ **Medical Ins. Claim** ☐ **Life Insurance** ☐ **Worker's Comp** ☐ **Attorney**

☐ **Other**_____________________________

I understand that I have the following rights with respect to this Authorization:

1. *The recipient of the protected health information is prohibited from redisclosing the information unless the recipient obtains another authorization from me or unless the disclosure is specifically required or permitted by law.*
2. *I may not be required to sign this Authorization as a condition to obtaining treatment or payment or my eligibility for benefits.*
3. *I may revoke this Authorization at any time by mailing or personally delivering a signed, written notice of revocation to Templeton Imaging, Inc. 262 Posada Suite C, Templeton, CA 93465.*

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Such revocation will be effective upon receipt, except to extent that the recipient has taken action in reliance on this Authorization.

4. *I am entitled to notice if Templeton Imaging, Inc. will use or disclose the protected health information for marketing and receive payment for the use or disclosure of my protected health information.*

I have read and understand the terms of this Authorization. I hereby, knowingly and voluntarily, authorize Templeton Imaging, Inc. to use or disclose my health information in the manner described on this form.

____ Date _________________
Signature of Patient/Personal Representative*

_______________________________________ _______________________________________
Personal Representative's Authority* Printed Name

***Personal Representative is any of the following:**
For an Incompetent Adult: A conservator of the patient's person or an agent appointed by patient under and Advance Health Care Directive/Power of Attorney for health care. ***For a Minor:*** A parent or guardian or other person *in loco parentis.* ***For a Deceased Patient:*** Executor, administrator or any beneficiary who stands inherit property from patient.

TO ACT ON PATIENT'S BEHALF
Identification of Patient/Personal Representative verified by: ______________________________

Driver's License # ___________________________________Other __________________________

**Supporting Documentation ____