Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to have 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**

This Authorization also allows for the transfer of the report of my thermal study by Physicians Insight's to be sent to me by the use of electronic medium (E-Mail). _____ (initial)

Effective dates for this authorization:

_____/_____/_____ (date of request) **THROUGH** **_____/_____/_____** **(**5 years 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 that 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 health information.

_____ _____

Signature of Patient or Patient's Authorized Representative Date:

_____ _____

Authorized Signature of Medical Thermography Associates Date: