MEDICAL DIAGNOSTIC IMAGING
14 Raymond Avenue, Poughkeepsie, NY 12603
1323 Route 9, Suite 107, Wappingers Falls, NY 12590
PHONE: (845) 471-2848 | FAX: (845) 471-2919

# AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

**PATIENT NAME**: _____
Last First

**ADDRESS:** _____
Street City State Zip

**DATE OF BIRTH**: _____ PHONE **NUMBER:** _____

I hereby authorize _____to **RELEASE** my protected health information to:
(Name of Provider)
**MD Imaging** located at: 14 Raymond Avenue, Poughkeepsie, NY 12603 and/or
1323 Route 9, Wappingers Falls, NY 12590
Phone: 845-471-2848
**INFORMATION REQUESTED**: Radiology Reports and Imaging

**EXAM: _____MRI _____CT _____ XRAY _____ULTRASOUND _____MAMMOGRAPY _____DEXA _____NUCLEAR**

Dates of care included: _____

1. I understand that I may inspect or obtain a copy of the protected health information described by this authorization.
2. I understand that MD Imaging, PLLC will not condition treatment, payment or (if applicable) enrollment in the health plan or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.
3. I understand that I may revoke this authorization in writing at any time by delivering such written revocation to the Privacy Officer of MD Imaging, PLLC. I also understand that such revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.
4. I understand that information used or disclosed pursuant to this authorization could be subject to re-disclosure by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

COPY PROVIDED: MD Imaging, PLLC shall provide a copy of this signed authorization to the patient if you request. This information has been disclosed to you from records whose confidentiality is protected by federal law. Federal regulations prohibit you from making any further disclosure of it without the specific written consent of the person to whom it pertains.

New York state law requires an individual or the individual's authorized legal representative to give specific consent for the release of protected health information related to certain disease conditions. By my signature above, I authorize the release of the following information that may be included in medical information held by MD Imaging of Poughkeepsie, including records of care and treatment for **HIV/AIDS**, records of **Mental Health** care and treatment, records of **Substance Abuse** care and treatment, records of **Genetic Testing,** records of **Sexually Transmitted Disease.**

___/___/___ _____
**DATE** **SIGNATURE OF INDIVIDUAL PATIENT OR REPRESENTATIVE**

**AUTHORITY OR RELATIONSHIP OF REPRESENTATIVE _____**

**DATE/EVENT THAT THIS AUTHORIZATION WILL EXPIRE: _____**
*(IF EXPIRATION DATE LEFT BLANK, THIS AUTHORIZATION WILL EXPIRE IN SIX MONTHS FROM THE DATE OF THIS REQUEST)*