**CONSENT OF DISCLOSURE - HIPAA AUTHORIZATION & NOTICE OF RECEIPT OF PRIVACY PRACTICES**

Patient:

DOB:

MRN:

PALM HARBOR MRI
32615 US HWY 19 N. STE #4
PALM HARBOR, FL 34684
Phone: 727-787-6900
Fax: 727-787-1892

I have been provided access to MRI Associates Notice of Privacy Practices. I understand that I am entitled to a copy of these practices at my request.

I furthermore acknowledge that I have the right to designate access to my Protected Health Information (PHI) to anyone of my choosing. I hereby authorize disclosure of my PHI to the following individual(s)

Authorized Individuals:

1.

2.

3.

I understand I may revoke this authorization at any time by submitting a written request to MRI Associates Privacy Officer, as per the office's Notice of Privacy Practices.

I understand that by signing this authorization,this information will be used by MRI Associates to make determinations for the release of my PHI. I also understand this authorization will remain in effect until I request an update and/or amendment.

**Patient Signature:** **Date:**