

Thermography Of Miami, LLC
Authorization to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: ____/____/____ Date of Request: _____

As required by the Privacy Regulations, Thermography of Miami, LLC may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations, Inc.

Patient Health Information authorized to be disclosed: **Thermal Images and related health history.**

For the specific purpose of: **Interpretation of said images.**

Effective date for this authorization: _____

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand 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, enrolment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

Signature of Patient or Patient's Authorized Representative

____/____/____
Date

Authorized Signature of Facility

____/____/____
Date