Albany Advanced Imaging, P.L.L.C.
Clifton Park Advanced Imaging, P.L.L.C.

Authorization to Use or Disclose Protected Health Information

I, _____, hereby authorize Albany Advanced Imaging, P.L.L.C. / Clifton Park Advanced Imaging, P.L.L.C. to use or disclose Protected Health Information of _____ in the following manner:
(Name of Patient)

Release to _____
(Name of person, office, or entity that is to receive the information)

at _____
(Address)

The following Protected Health Information: _____
_____
_____
(Describe the information to be used or disclosed, including date of service, type of service, level of detail to be released, or other specific information)

The Protected Health Information is being used or disclosed for the following purpose(s):_____
_____
(List specific purposes for use/disclosure of the Protected Health Information)

This authorization is in full force and effect until ____ / ____ / _____ or at the time of the following event or occurrence: _____
_____, at which time this authorization to use or disclose Protected Health Information expires.

I understand that I have the right to revoke this authorization in writing by sending notification to:
Michael J. Whalen
Albany Advanced Imaging, P.L.L.C.
3 Atrium Drive
Albany, NY 12205

I understand when I revoke this authorization, it is not effective to the extent that Albany Advanced Imaging, P.L.L.C. / Clifton Park Advanced Imaging, P.L.L.C. has already relied on it to use or disclose the Protected Health Information.

_____ ____ / ____ / _____
(Signature) *(Date)*

_____
(Relationship to the Patient)