



Lake Medical Imaging & Vascular Institute

Patient Authorization for Use and Disclosure Of Protected Health Information “For Release of LMI Records to Patient or Other”

Please send the following study / exam images / copy of the report(s).

Study / Exam images / copy of report(s) being requested: _____

Date(s) of Exam(s): _____

This authorization remains effective for one year from the date signed.

I do not have to sign this authorization as a condition for receiving treatment from Lake Medical Imaging and Vascular Institute. When information about me is used or disclosed pursuant to this authorization, I understand it may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Rule.

I have the right to revoke this authorization, in writing, except to the extent that the practice has acted in reliance upon this authorization.

My written revocation must be submitted to the Privacy/Compliance Officer at:

Janice Blakeley, Privacy/Compliance Officer
Lake Medical Imaging & Vascular Institute
801 E. Dixie Ave., Suite 104
Leesburg, FL 34748

I authorize LAKE MEDICAL IMAGING AND VASCULAR INSTITUTE to release certain protected health information (PHI) about me to:

_____ My personal representative indicated below.

_____ Other _____

Patient Signature

Print Patient Name

Patient Date of Birth

Daytime phone number

or Personal Representative /Guardian Signature

Print Personal Representative/Guardian Name

Relationship to Patient

Witness Signature

Print Witness Name

Date Signed

Developed 7/1/2009