



# Lake Medical Imaging & Vascular Institute

## Patient Authorization for Use and Disclosure Of Protected Health Information General

Please send the following study / exam images and a copy of the report(s) to:

LAKE MEDICAL IMAGING  
801 E. Dixie Ave., Suite 104  
Leesburg, FL 34748  
352-787-5858

Study / Exam images and report(s) being requested: \_\_\_\_\_

Date(s) of Exam(s): \_\_\_\_\_

The information will be used or disclosed for the following purpose: **Comparison and/or Radiological Medical Imaging Evaluation**  
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 \_\_\_\_\_ to release certain protected health information (PHI) about me to the above location.

\_\_\_\_\_  
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