

AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEDICAL INFORMATION

Treatment, payment, enrollment or eligibility for benefits will not be conditioned on my providing or refusing to provide the authorization.

I hereby authorize the physicians and/or employees of _____ to release medical information as indicated below.

Release records and information regarding:

Name of Patient (List Other Names Used): _____ Date of Birth: _____

Address: _____ Telephone Number: _____

Medical Record #: _____

Release medical information to: **Scandoc Imaging, Inc. 500 Superior Ave Suite 320, Newport Beach, Ca 92663**

DURATION: This authorization shall become effective immediately and shall remain in effect until _____ (Enter Date) or for one year from the date of signature if no date entered.

REVOCAATION: This authorization is also subject to written revocation by undersigned at any time between now and the disclosure of information by the disclosing party. Written revocation will be effective upon receipt, but will not be effective to the extent that the Requestor or others have acted in reliance upon this Authorization.

REDISCLASURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law.

SPECIFY RECORDS: Check the box and initial which type of information is to be disclosed:

- MEDICAL INFORMATION**
- PSYCHIATRIC INFORMATION** _____ Signature _____ Date
- DRUG/ALCOHOL** _____ Signature _____ Date
- HIV TEST RESULTS** _____ Signature _____ Date
- OTHER (Specify)** _____

I request that the health information released pursuant to this authorization be used for the following purposes only:

A copy of this authorization is valid as an original.

I have a right to receive a copy of this authorization. The copy is for me to keep.

Date

Signature of Patient or Patient's Representative

Indicate Relationship (If Signed by Other Than Patient)