CHARTER RADIOLOGY
WHERE COMPASSION AND EXPERTISE COME TOGETHER

AUTHORIZATION FOR USE/DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this form, I acknowledge that I have received a copy of Charter Radiology's Notice of Privacy Practices which provides information about ways my protected health information ("PHI") may be used and disclosed by Charter Radiology and states my rights with respect to my PHI. I understand that Charter Radiology has the right to revise these practices and if the terms of the Notice of Privacy Practices change, a revised Notice will be made available to me. Please note: In accordance with Maryland Law, we may destroy patient charts 6 years after the last documented record. In the case of a minor, records, must be retained until the patient reaches the age of 18 plus 3 years, or for 5 years after the record was made, whichever is later.

In addition, by signing this form, I hereby voluntarily authorize the use and/or disclosure of all or any part of my PHI as described in this Authorization by Charter Radiology and its employees, agents, and third parties acting on its behalf as follows: (1) anonymous images of me may be used by Charter Radiology for teaching or educational purposes and (2) in order to facilitate the healthcare services provided to me, Charter Radiology may engage in the following:

- Call, email or send a text to me to confirm appointments Yes____ No____
- Leave a message on my home answering machine and/or cell phone Yes____ No____
- Discuss my medical condition with the following individuals: (i.e. relative or friend)

Name of Individual	**Phone Number**	**Email Address**
_____	_____	_____

My signature below means that I understand and agree to the following:

- My PHI may be protected by law. My PHI that is disclosed under this Authorization may be re-disclosed by the recipient and no longer protected by federal privacy regulations.
- Charter Radiology will not condition my treatment on whether I sign this Authorization.
- Without my signature below, this Authorization will not be honored.
- I may receive a copy of this form if I ask for it in writing addressed to Charter Radiology at the address listed at the bottom of this page.
- This authorization will expire six (6) years from the date set forth below, unless I revoke it sooner. If I sign this form, I may revoke this Authorization at any time by notifying Charter Radiology in writing at the address below. Revoking this Authorization will not have any effect on actions that Charter Radiology took in reliance on the Authorization before it received notice of my revocation.

_____ _____
Signature of Individual or Representative Date

_____ _____
Printed Name of Individual Relationship to Individual (if signed by Personal Representative)