



HILLSBOROUGH RADIOLOGY CENTERS

A Partnership of Princeton Radiology & University Radiology

ROUTE 206
375 Route 206
Hillsborough, NJ 08844
908.874.7600

RAIDER BLVD
105 Raider Blvd.
Hillsborough, NJ 08844
908.359.9331

AUTHORIZATION TO DISCLOSE PATIENT INFORMATION

Purpose:

This form is to be used for including, but not limited to: patient's telephone, fax or mail requests for films, reports or disclosures and for non-TPO requests.

I, _____ hereby authorize Hillsborough Radiology to disclose my health information described below to:

Recipient Name: _____

Recipient Address: _____

Recipient Telephone Number: _____

Films/Documents/Information To Be Released: _____

Purpose of Disclosure (explain or indicate "at the request of the individual"): _____

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act of 1996, and its implementing regulations ("HIPAA"). I understand that I have the right to revoke this authorization, at any time prior to the Hillsborough Radiology's compliance with the request set forth herein, provided that the revocation is in writing. I further understand that additional information relating to the exceptions to the right to revoke and a description of how I may revoke this authorization is set forth in Hillsborough Radiology's Notice of Privacy Practices. I understand that any revocation must include my name, address, telephone number, date of this authorization, my signature, and that I should send it to:

Hillsborough Radiology
375 Route 206
Hillsborough, NJ 08844
Attn: Privacy Officer

I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the Recipient listed above and, in that case, will no longer be protected by HIPAA.

This authorization expires upon Hillsborough Radiology's release of the information described above or thirty days after the Date of Authorization, as set forth below, whichever comes first.

Signature of Individual or Personal Representative

Patient's Date of Birth

Description of Personal Representative's Authority

Date of Authorization