Thermography Center
OF FAIRFAX

Authorization to Use or Disclose Protected Health Information

Patient Name:_____
Address:_____
State/Zip:_____ Date of Birth:_____

As required by the Privacy Regulations, *Thermography Center of Fairfax, LLC* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: Thermal Images and related health history
For the specific purpose of (describe in detail) Interpretation of said images

I request my Report and Images to be sent to me:

Via email on a PDF Report (No Charge) email address:_____

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Refuse to sign this authorization.
4. Receive a copy of this authorization.
5. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature or Patient or Patient's Authorized Representative Date

_____ _____
Authorized Signature of Facility Date