



# Grossman Imaging Centers

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Medical Director

## HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information  
(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

Patient Name: \_\_\_\_\_ MRN: \_\_\_\_\_

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ E-mail Address: \_\_\_\_\_

I \_\_\_\_\_, hereby authorize and request \_\_\_\_\_ to release my health information (PHI) to:

**Grossman Imaging Center  
C/O: Medical Records Department  
2001 N. Solar Drive #135  
Oxnard, CA 93036**

☐ Films/ CD ☐ Reports

In addition to the authorization for release of my PHI described above this Authorization, I furthermore acknowledge that I have the right to authorize access and disclosure of my Protected Health Information (PHI) to anyone of my choosing for billing, condition, treatment and prognosis to the following individual(s):

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Relationship \_\_\_\_\_

I request the following restriction (s) to releasing my PHI:

I understand that I am entitled to a copy of Grossman Imaging Center's Notice of Privacy Practices. I can access a copy of the Notice of Privacy Practices from the website [www.grossmanimagingcenter.com](http://www.grossmanimagingcenter.com) or from the office directly.

I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim. Unless otherwise revoked this authorization shall be in force and effect one year from today's date at which time this authorization expires.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date: