Authorization to Use or Disclose Protected Health Information InsideOut Thermography

Patient Name:	
Ac	ldress:
Da	ate of Birth: Date of Request:
no	required by the Privacy Regulations, <i>InsideOut Thermographic Imaging</i> may t use or disclose your protected health information except as provided in our otice of Privacy Practices without your authorization.
	ereby authorize this office and any of its employees to use or disclose my Patient Health Information to the owing person(s), entity(s), or business associates of this office:
	EMI, Electronic Medical Interpretations
Pa	tient Health Information authorized to be disclosed: Thermal Images and related health history
	the specific purpose of (describe in detail) Interpretation of said images
Thi I ur	ective dates for this authorization:/ through// s authorization will expire at the end of the above period. Inderstand that the information disclosed above may be re-disclosed to additional parties and no longer protected reasons beyond our control.
Ιu	inderstand 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.	Inspect a copy of Patient Health Information being used or disclosed under federal law.
4.	Refuse to sign this authorization.
5.	Receive a copy of this authorization.
6.	Restrict what is disclosed with this authorization.
pla	so understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health n, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health ormation.
Sig	nature or Patient or Patient's Authorized Representative Date
Au	thorized Signature of Facility Date