AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

DREW MEDICAL, INC. Corporate Office: 9582 West Colonial Drive, Ocoee, Florida 34761

Section A: Must be completed for all authorizations.

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary.

I authorize Drew Medical, Inc. to release films and/or reports regarding my radiographic exams to treating healthcare providers that will be providing medical treatment or services to me.

Patient Name: ______________________ DOB ______________ ID Number: ______________

Persons/Organizations Providing the Information: ______________________

Persons/Organizations Receiving the Information: __________ **DREW MEDICAL,INC.** __________

Specific Description of Information Requested (Including Dates): ______________________

❑ Send Records To: DREW MEDICAL ______________________

❑ Fax Reports To: DREW MEDICAL ______________________

❑ Courier will pick-up on ______________________

❑ Patient will pick-up on ______________________

CONTACT ______________________
(Employee Name and Phone Number)

Section B: Must be completed only if the healthcare organization has requested the authorization.

The health plan or health care provider must state the purpose or use of this disclosure

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Section C:

ATTENTION PATIENT

The patient or the patient's representative must read and sign the following statements:

You have the right to revoke this Authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance on this Authorization.

Unless revoked earlier or otherwise indicated, this Authorization will expire 180 days from the date of signing or shall remain in effect for the period reasonably needed to complete the request.

I have reviewed and I understand this Authorization. I also understand that the information used or disclosed pursuant to this Authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

I am aware that it is my responsibility to obtain any prior exam(s) related to today's study. I am aware that if I do not produce my prior exam(s) needed for a complete dictation within 24 hours of my exam date, that my exam will be dictated with a notation that prior films were unavailable.

X By ______________________ Date ______________
(Patient Signature)

X Or By ______________________ Date ______________
(Patient's Representative's Signature)

Description of Representative's Authority ______________________