Patient Authorization for Use or Disclosure of Protected Health Information

I, _____DOB_____ hereby authorize Sound Diagnostics*, LLC* to:

_____ **Use** the following Protected Health Information, and/

_____ **Disclose** the following Protected Health Information to: _____

Requested PHI: _____

This Protected Health Information is being used or disclosed for the following purpose(s):
Continuation of care

I direct and hereby authorize _____ to deliver/receive the Protected Health Information specified in this Authorization to the party or parties specified in the following medium, if available:

- Hardcopy Format, such as paper or facsimile (fax).
- Electronic Format, such as CD-ROM or flash drive (memory stick).
- Email.
- No Format Preference.

I understand that electronic media, and delivery methods such as email, pose certain risks to the privacy and security of my Protected Health Information that may be beyond the control of *Sound diagnostics* . I agree to assume such risks personally, and to hold *Sound Diagnostics* harmless in the event my Protected Health Information is breached or compromised as a result of my directing and authorizing
Sound Diagnostics to transmit or receive such information electronically.

This Authorization shall be in force and effect until _____ at which time this Authorization to use or disclose this Protected Health Information shall expire.

I understand that I have the right to revoke this Authorization, in writing, at any time by sending such written notification to Sound Diagnostics at *875 Bridger Drive Ste G, Bozeman, MT 59715* .

I understand that information used or disclosed pursuant to this Authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

Sound Diagnostics LLC will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide Authorization for the requested use or disclosure.

I understand that I have the right to:

- Inspect or copy the Protected Health Information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Have an electronic copy of my medical records, or a portion thereof, transmitted to any third party or person I designate.
- Refuse to sign this Authorization.

_____ _____
Signature of Patient or Personal Representative Date

Please Mail hard copy of image files to; _____

Sound Diagnostics
875 Bridger Drive Ste G Bozeman, Mt
FAX-406-205-0124
Phone-406-624-6727

▼▼▼ FOR OFFICE USE ONLY ▼▼▼

Received by:			
Date Received:		Time Received:	
Action(s) Taken:			
PHI Disclosed To:			
Disclosure Media:	☐Hardcopy ☐Memory Stick ☐CD-ROM ☐Email ☐Other (describe)		

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Discloser Signature:	