UNIVERSITY RADIOLOGY

PATIENT CONSENT TO DISCLOSE MEDICAL INFORMATION TO DESIGNEES

I, _____ authorize University Radiology Group to disclose my health information to the individuals listed below:

I understand that my designees will be required to provide photo identification when requesting my health information.

In addition to the individuals listed below, I acknowledge that University Radiology Group may share my health information with my healthcare provider or as otherwise required by law.

I understand that the terms of this authorization are governed by the Health Insurance Portability and Accountability Act ("HIPAA"). I understand that I have the right to revoke this authorization or change the list of designated individuals at any time by mailing a letter expressly stating this fact and including my name, address, telephone number and my signature and that I should send it to:

University Radiology Group
579A Cranbury Road
East Brunswick, NJ 08816
Attn: Privacy Officer

Such cancellation or change in authorization shall be effective as of the date of University Radiology Group's receipt of my letter cancelling or modifying my authorization.

Designated Individuals:

Print Name	Relationship to Patient
Print Name	Relationship to Patient

Patient Information:

Patient's Signature	Patient's Date of Birth
Patient's Telephone Number	Date of Authorization