

ADVANCED IMAGING OF PORT CHARLOTTE, LLC
2625 Tamiami Trail, Suite 101
Port Charlotte, FL 33952
Phone 941-235-4646 Fax 941-235-4655

Authorization for Care and Release of Health Information

X Patient _____ Date of Birth _____ SS# _____

X Address _____ Telephone _____

X City & Zip _____ Cell Phone _____

I authorize _____ to release my information to:

_____ Advanced Imaging _____

This authorization for release of information is valid for **90 days** from the date of signature, unless revoked by written notice to the providing institution. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. I understand that once the information is disclosed pursuant to this authorization, the recipient may re-disclose it and the authorization will not affect my ability to obtain treatment, receive payment, or eligibility for benefits unless allowed by law.

I grant permission to the employees of Advanced Imaging of Port Charlotte to render care to me and expedite the orders of the physicians and/or physician extender. I further authorize release of this information to other healthcare providers associated with my care.

I agree that I will be financially responsible for any reasonable and customary charges should my treatment not be covered by my insurance company or responsible party due to denial, deductible or co-pay.

Patient Signature: **X** _____ Date _____

Acknowledgement of Receipt of Notice of Privacy Practices

Your name and signature on this section indicates that you have received a copy of Advanced Imaging's Notice of Privacy Practices on the date indicated. If you have any questions regarding the information in our Notice of Privacy Practices, please do not hesitate to contact our Patient Privacy Officer at 941-235-4646.

Patient Signature: **X** _____ Date _____

If Patient Representative, Name (printed): _____

Patient Representative Signature: _____