ATLANTIC RADIOLOGY
Pooler Imaging Center

HIPAA Authorization and Notice of Receipt of Privacy Practices

PATIENT:
DOB:
DATE:

I authorize Atlantic Radiology Associates (Pooler Imaging/ Moss Creek MRI) to provide all copies/records of my radiology reports and/or images to any hospital, physician, or healthcare provider upon their request.

I intend for this authorization to satisfy the requirements of the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

Please list any family members or other persons to whom we may release information concerning your medical record. Please be advised we will not release any information to person(s) not listed on this form.

Name: _____ **Phone:** _____

Name: _____ **Phone:** _____

Signature:_____