I, (Print Name)_____, (DOB ____/____/____) authorize the release of my Protected Health Information as indicated below:

- ☐ Specific Exam(s)_____
- ☐ All Exams

Types of Information:

- ☐ Reports
- ☐ Images
- ☐ Billing Information
- ☐ All Protected Health Information

Dates of Service:

- ☐ Specific Date(s) ____/____/____ to ____/____/____
- ☐ All previous and future dates of service
- ☐ All future dates of service

To the individuals listed below:

Name	Address	Relationship
Name	Address	Relationship
Name	Address	Relationship
Name	Address	Relationship

Signature must match the signature on file!

_____	____/____/_____	_____
Signature	Date	Contact Phone Number

I understand that I have the right to revoke this authorization in writing by sending notification to:
Fairfax Radiological Consultants, P.C.
Attention: Privacy Officer
2722 Merrilee Drive, Suite 230
Fairfax, VA 22031-4400

I understand when I revoke this authorization, it is not effective to the extent that Fairfax Radiological Consultants, P.C has already relied on the use or disclose of the Protected Health Information. I also understand Protected Health Information released prior to this authorization may be re-disclosed by the party who received that information and may no longer be protected by federal or state law. Fairfax Radiological Consultants, P.C will not condition my treatment or payment on whether I provide an authorization for the requested use or disclose.

This completed, signed form may be mailed, faxed or hand presented to any patient care center for record release. If faxed (703-698-0864) or mailed, please allow 48 business hours for the document to be attached to the patient record.