Authorization to Use or Disclose Protected Health Information
Thermography Ltd., LLC

Patient Name: _____
Address: _____
Date of Birth: _____ Date of Request: _____

As required by the Privacy Regulations, *Thermography Ltd., LLC* may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your authorization.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

EMI, Electronic Medical Interpretations

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of (describe in detail)
Interpretation of said images

I understand I have the right to:

1. **Revoke this authorization by sending written notice to this office and that revocation will not affect this Office's previous reliance on the uses or disclosure pursuant to this authorization.**
2. **Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.**
3. **Inspect a copy of Patient Health Information being used or disclosed under federal law.**
4. **Refuse to sign this authorization.**
5. **Receive a copy of this authorization.**
6. **Restrict what is disclosed with this authorization.**

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected patient health information.

_____ _____
Signature or Patient or Patient's Authorized Representative **Date**

_____ _____
Authorized Signature of Facility **Date**