# HIPAA AUTHORIZATION

This Authorization is required by the HIPAA Privacy Rule. [[1]](#footnote-1) By completing and signing this Authorization, you permit the release of Protected Health Information[[2]](#footnote-2) (**PHI**) contained in a Designated Record Set[[3]](#footnote-3) maintained by vRad[[4]](#footnote-4). Send the completed form by fax or mail to:

 **fax :** 952-516-5772 **mail:** vRad

 3600 Minnesota Drive, Suite #800,

 Edina, Minnesota, 55435

 attention: OGC.

If you have questions about this Authorization: **vRad’s Privacy Contact**, Karen Scott: 952-595-1198.

# YOUR REQUEST

1. **Patient name: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**
2. **Requests the following items:**

 \_\_\_ Radiology Report(s) \_\_\_ Other (specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

 \_\_\_\_ Billing information

**vRad does not maintain your complete medical record. The radiology report and radiology images are part of your medical record maintained by your primary provider or hospital.**

1. **Select one:** All records [ ] or Records between these dates \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_
2. **Release the information to:**

Organization name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

And/or person name:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Mailing address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Phone number:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you want your PHI to be provided to the organization/person by email, provide the email address.
It will be sent encrypted. However, you assume all risk of transmitting PHI via email.**

Email address:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**If you want your PHI to be provided to the organization/person by fax, please provide the fax number.**

Fax:\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

**5. This Authorization will expire one year after the date that I sign this Authorization unless I indicate an earlier date or event here\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_.**

# INFORMATION TO HELP US IDENTIFY YOUR RECORDS

**We will only release information we reasonably believe to be your PHI, therefore the more information you can provide, the more likely we will be able to isolate your information from other individuals with similar names and birth dates.**

\*Patient name:

\*Patient date of birth:

\*State where care was provided: \_

\*Dates of vRad’s radiology service:

**\* Required**

Other names I have gone by: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Last 4 digits of my SS#: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Hospitals that have treated me (Name and State): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Reviewing Radiologists’ Name(s): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Other information (i.e., MRN, procedure) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

# YOUR RIGHTS

* If your PHI is released to someone who is not required to comply with the HIPAA Privacy Rule, such information may be re-disclosed and would no longer be protected by the Privacy Rule.
* vRad does not condition treatment on whether you sign this Authorization.
* You have the right to revoke this Authorization before the date in item #5 by notifying vRad, in writing. The revocation will not have any effect on actions taken in reliance on the Authorization.

#  SIGNATURE

By your signature, you certify that: (a) you have read this Authorization; (b) you have discussed any questions you have with vRad’s Privacy Contact; (c) you agree to the release of PHI as described in this Authorization.

**I am the: [ ] Patient [ ] Parent or Guardian [ ] Personal Representative**

|  |  |  |
| --- | --- | --- |
| **Signature:** |  | **Date:**  |
| **Printed Name:** |  |   |

**Personal representative must include a copy of the verification of authority to act on behalf of patient.**

1. “**HIPAA**” stands for the Health Insurance Portability and Accountability Act of 1996. The “**Privacy Rule**” refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA. [↑](#footnote-ref-1)
2. “**Protected Health Information**” is information (i) about your physical or mental health or condition, health care, or the payment for the health care; (ii) that identifies you directly or indirectly *(i.e.*, there is a reasonable basis to believe that the information could be used to identify you); and (iii) that is maintained or transmitted by a Health Care Provider (or other Covered Entity) or its Business Associate. [↑](#footnote-ref-2)
3. The **Designated Record Set** vRad maintains consists of radiology reports issued by vRad radiologists and billing statements sent to the patient and the payment guarantor(s). [↑](#footnote-ref-3)
4. “**vRad”** means Virtual Radiologic Professionals, LLC, Virtual Radiologic Corporation (**VRC**), and any other entity or affiliated medical practice under Virtual Radiologic Corporation’s management. [↑](#footnote-ref-4)