P: 952.595.1100
F: 952.942.3361
www.vrad.com

11995 Singletree Lane, Suite 500
Eden Prairie, MN 55344

HIPAA AUTHORIZATION

By completing and signing this Authorization you, _____ (the "Patient"), agree to the release of your Protected Health Information[1] (PHI) contained in a Designated Record Set as outlined below. This Authorization is intended to comply with the authorization requirements of the HIPAA[2] Privacy Rule.[3] If you agree with this Authorization, please sign and date it at the end of this form, and **fax it to 952-516-5772.**

I. INFORMATION ABOUT THE RELEASE

1. My authorization applies to the following items in the Designated Record Set:

___ Radiology Report(s) ___ Other (specify) _____

____ Billing information

Note that vRad does not maintain images as part of the Designated Record Set, and the radiology report is part of your medical record maintained by your primary provider or hospital. vRad does not maintain your complete medical record.

2. Select: All records [ ] or Only records between these dates:_____

3. Release the information to:

Organization name:_____

And/or person name:_____

Mailing address:_____
_____
_____

[1] "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.

[2] "HIPAA" stands for the Health Insurance Portability and Accountability Act of 1996.

[3] The "Privacy Rule" refers to regulations issued by the U.S. Department of Health and Human Services pursuant to HIPAA.

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Phone number:_____

If you want your PHI to be provided to the organization/person by email, please provide the email address. It will be sent encrypted.

Email address:_____

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

Fax:_____

I understand that if my 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.

4. This Authorization will expire one year after the date that I sign this Authorization unless I indicate an earlier date or event here_____.

II. INFORMATION ABOUT YOUR RIGHTS

- I understand that I have the right to refuse to sign this Authorization. vRad Subject entities will not condition treatment on whether I sign this Authorization.
- I understand that I have the right to revoke my Authorization prior to the expiration date (in item #4) by notifying vRad Subject Entities, in writing, but the revocation will not have any effect on actions taken in reliance on the Authorization.

III. INFORMATION TO HELP US IDENTIFY YOUR RECORDS

Please provide as much information as possible.

My date of birth:_____

State I lived in at the time of my care:_____

State where care was provided, if other than home state:_____

Other names I have gone by: _____

My date(s) of injury: _____

Last 4 digits of my SS#: _____

Dates I know I was seen by your physician(s):_____

Hospitals that have treated me (Name and State):_____
Reviewing Radiologists' Name(s): _____

Other information: _____

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We will only release information we reasonably believe to be <u>your</u> 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.

III. SIGNATURE

By my signature, I certify that: (a) I have read this Authorization; (b) I have discussed any questions I have with the vRad Subject Entities Privacy Official; (c) I agree to the release of my PHI as described in this Authorization; and (d) I have retained a signed copy of this Authorization.

_____ Signature of Patient	Date: _____
OR _____ Signature of personal representative, or parent if patient is a minor _____ Printed name of parent or personal representative	Date: _____ Basis for representation if other than parent: _____ (Please include verification of authority to act on behalf of patient)

If you have questions about this Authorization, please contact vRad's Privacy Officer: 952-595-1198.

"vRad Subject Entities" means: (1) Virtual Radiologic Professionals, LLC ("VRPLLC" or the "Practice"); (2) certain "mini-Practices" (currently VRPCA, VRPNY and VRPTX), all of which are HIPAA Covered Entity Health Care Providers; (3) other current mini-Practices, which are or could become Health Care Providers (currently, VRPIL, VRPMI, and VRPMN); (4) Virtual Radiologic Corporation ("VRC"), which is a HIPAA Business Associate of the Practice and the mini-Practices that are Covered Entities; and (5) any other entity or affiliated medical practice under the management of, and specifically designated as a Subject Entity by, VRC. Where compliance is not required by HIPAA with respect to any of the foregoing because it is not a Covered Entity, such entity has voluntarily chosen to seek to comply with the requirement to the extent reasonable and appropriate in its sole discretion. VRC will act on behalf of the vRad Subject Entities.