Southern Diagnostic Imaging
1037 North Flowood Drive ~ Flowood, MS 39232
601-936-0302

Authorization for Use of Disclosure of Protected Health Information

I authorize my physician, and/or administrative and clinical staff of Southern Diagnostic Imaging to disclose general medical information and other protected health information to the following persons and/or entities listed below. If no one is listed below, protected health care information will not be disclosed except in those situations described in the Notice of Privacy Practices of Southern Diagnostic Imaging.

Name and relationship of person who you wish to allow access – for example, your spouse, sibling, neighbor, caretaker, or close friend:

Name of person or Entity	Relationship

This authorization to use and disclose this protected health information is being submitted by my request and shall be in force and effect until revoked in writing by me.

I understand that information used or disclosed pursuant to this authorization may be disclosed by Southern Diagnostic Imaging and may no longer be protected by federal or state law.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such a written notification to the practice's Privacy Contact at 1037 North Flowood Drive, Flowood, MS 39232 and understand that a revocation is no effective to the extent that my physician has relied on the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

_____
Signature of Patient or Personal Representative

_____
Date