TIMBERRIDGE IMAGING CENTER OF OCALA
PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize TimberRidge Imaging Center to use and/or disclose certain protected health information (PHI) about me to RECORDS DEPOSITION SERVICE, INC.

(Person or Entity to receive the information)

PO BOX 5054, SOUTHFIELD, MI 48086-5054 P: 248.357.3330 E: REQUESTS@RECDEP.COM

This authorization permits TimberRidge Imaging Center to use and/or disclose the following individually identifiable health information about me (specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.). PLEASE SEE ATTACHED SUBPOENA OR REQUEST FOR INFORMATION

The information will be used or disclosed for the following purpose: LEGAL DISCOVERY. If requested by the patient, purpose may be listed as "at the request of the individual." The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on _____.

(Expiration Date or Defined Event)

The Practice will not receive payment or other remuneration from a third party in exchange for using or disclosing the PHI. I do not have to sign this authorization in order to receive treatment from TimberRidge Imaging Center

In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization.

Under Rule 64B8-10.003, Florida Administrative Code, TimberRidge Imaging Center can charge $1.00 per page up to 25 pages and .25 for each additional page thereafter. Additionally, Medical Imaging Center will charge a prepaid fee of $40.00 per CD/per exam.

My written revocation must be submitted to the Privacy Officer at: PO Box 6200, Ocala, FL 34478-6200

Signed by:_____ _____

Signature of Patient or Legal Guardian — Relationship to Patient

_____ _____

Print Patient's Name – SSN — Print Name of Legal Guardian

State of Florida,

County of _____

Sworn to (or affirmed) and subscribed before me this _____ day of _____, 20____,

by _____ who is personally known to me OR produced identification (identification produced: _____).

_____

Signature of Notary

(Notary seal)

_____

Printed/typed name of Notary