

SOUTH JERSEY RADIOLOGY ASSOCIATES

**HIPAA Authorization**

Patient Name: \_\_\_\_\_

Patient DOB: \_\_\_\_\_ Telephone Number: \_\_\_\_\_

- ☐ I hereby Authorize South Jersey Radiology Associates, to disclose/release my medical information  
(Including, Reports, Images, Results and Financial Activity) to:

\_\_\_\_\_  
(Please Print) Relationship: \_\_\_\_\_  
(Please Print)

\_\_\_\_\_  
(Please Print) Relationship: \_\_\_\_\_  
(Please Print)

\_\_\_\_\_  
(Please Print) Relationship: \_\_\_\_\_  
(Please Print)

SJRA will ask you to review your Authorization each year. This consent will remain in effect until  
revised or revoked by the Patient or Legal Guardian.

- ☐ I do not Authorize South Jersey Radiology Associates, to disclose/release my medical information  
(Including, Reports, Images, Results and Financial Activity) to:

\_\_\_\_\_  
(Please Print)

\_\_\_\_\_  
(Please Print)

PATIENT or Legal Guardian: \_\_\_\_\_  
(Please Print Name)

**X** \_\_\_\_\_  
PATIENT or LEGAL GUARDIAN SIGNATURE Date

\_\_\_\_\_  
Witness Date