AMERICAN RADIOLOGY SERVICES. INC.
AUTHORIZATION FORM TO DISCLOSE PROTECTED HEALTH INFORMATION

I hereby authorize American Radiology Services, Inc. ("ARS") personnel to disclose my protected health information to the persons/organizations I have identified below for the purpose of having such persons/organizations assist me in resolving outstanding billing issues with ARS or American Radiology Associates, P.A. I understand that the information I authorize a person or entity to receive may be re-disclosed and no longer protected by federal privacy regulations.

1. Persons/organizations to whom I authorize ARS to disclose the information:
____

2. The information that I authorize be disclosed includes the medical services rendered to me by ARS or American Radiology Associates, P.A., insurance and other payments and or denials, and my demographic information including social security number and date of birth.:
Other information to be disclosed:____

3. The information is being disclosed at my request for the purpose of resolving outstanding billings for services provided to me by ARS or American Radiology Associates, P.A..
Other purposes:____

4. I understand that this authorization is voluntary and that I may refuse to sign this authorization. Unless allowed by law, my refusal to sign will not affect my ability to obtain treatment; receive payment or eligibility for benefits.

5. I understand that I may revoke this authorization at any time by notifying ARS in writing. However, the revocation will not be valid if ARS has taken action in reliance on this authorization.

6. This authorization expires on ___________[insert applicable date or event not to exceed one year]. If no expiration date is provided in the previous sentence, this authorization will expire one (1) year from the date signed below.

SIGNATURES:

_____________________________________ _________________________
Signature of patient or patient's representative: Date

_____________________________________ _________________________
Printed name of patient or patient's representative: Relationship to patient or Authority to act for the patient

_______________________________________ _________________________
Signature of witness Date

Patient's Social Security Number:___________________
Patient's Date of Birth:___________________________

Mail to: American Radiology Services, Inc.
P.O. Box 17513
Baltimore, MD 21297

Fax to: (410) 902 - 7473