PRISMATIC MEDICAL THERMOGRAPHY

Authorisation to Use or Disclose Protected Health Information

Patient Name: _____

Address: _____

Date of Birth: _____ Date Request: _____

As required by the Privacy Regulations, Prismatic Medical Thermography, may not use or disclose your protected health information except as provided in our Notice of Privacy Practices without your Authorisation.

I hereby authorize this office and any of its employees to use or disclose my Patient Health Information to the following person(s), entity(s), or business associates of this office:

_____

Patient Health Information authorized to be disclosed: **Thermal Images and related health history**

For the specific purpose of: **Interpretation of said images**

Effective date for this Authorisation : _____

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

- Revoke this Authorisation by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this Authorisation
- Knowledge of any remuneration involved due to any marketing activity as allowed by this Authorisation, and as a result of this Authorisation .
- Inspect a copy of Patient Health Information being used or disclosed under federal law.
- Refuse to sign this Authorisation .
- Receive a copy of this Authorisation .
- Restrict what is disclosed with this Authorisation .

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrolment in a health plan, or eligibility for benefits whether or not I provide Authorisation to use or disclose protected patient health information.

Signature or Patient or Patient's Authorised Representative _____ Date _____

Authorised Signature of Facility _____ Date _____