

The purpose of this form is for the patient to authorize sending New England Clinical Thermography to send images to the interpretation service (EMI). They are a separate company and we cannot send your images and the accompanying medical history without your permission.

Authorization to Use or Disclose Protected Health Information to The EMI Interpretation Service

Patient Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

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

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:

EMI, Electronic Medical Interpretations

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

For the specific purpose of (describe in detail) - **Interpretation of thermal images**

Effective dates for this authorization: ____/____/____ through ____/____/____

This authorization will expire at the end of the above period. **(Leave dates blank if you would like this authorization to be on-going.)**

I understand I have the right to:

1. Revoke this authorization 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 authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Patient Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

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

Signature or Patient or Patient's Authorized Representative _____
Date

Authorized Signature of Facility _____
Date