Nuclear Medicine Associates
1950 Court Street
Redding, CA 96001
(530) 225-8008

AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I authorize use or disclosure of the named individual's health information as described below:

Patients Name:_____________________________ DOB: ____/____/____

1. **The following individual or organization is authorized to make the disclosure**:
   - ____ Peter Robbins, M.D.
   - ____ Rhonda Wyatt, M.D.
   - ____ Nuclear Medicine Associates
   - ____ Other (specify name) ____

     (specify address)____
2. **This information may be disclosed to and used by the following individual or organization:**
   - ____ Peter Robbins, M.D.
   - ____ Rhonda Wyatt, M.D.
   - ____ Nuclear Medicine Associates
   - ____ Other (specify name) ____

     (specify address)____
3. **Purpose of request**: ____

   (If purpose is not designated we will state "at the request of the individual")
4. **This authorization permits use and/or disclosure of the following individually identifiable health information.**

   (Specifically describe the information to be used or disclosed, such as date(s) of services, type of services, level of detail to release, origin or information, etc.)
5. **Expiration:** Unless otherwise revoked, this authorization will expire on the following date, event or condition:

____

(If I do not specify an expiration date, event or condition, this authorization will expire in six months from date signed.)

Re-disclosure: I understand that when my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by federal HIPPA Privacy Rule.

Right to revoke: I understand that I have the right to revoke this authorization in writing except to the extent that the individual or organization I authorized above to disclose my health information.

Other rights: I understand that authorizing this disclosure is voluntary. I can refuse to sign this authorization. I do not need to sign this form in order to receive treatment.

________________________________ ________________________________

Signature of Patient or Legal Guardian   Relationship with Patient

________________________________ ________________________________

(Print Name if Legal Guardian)   Date Signed