National Scoliosis Center/3-D Body Imaging, LLC

HIPAA Authorization Form

Patient Authorization for Use and Disclosure of Protected Health Information

By signing, I authorize National Scoliosis Center/3-D Body Imaging, LLC (NSC/3D) to use and/or disclose certain protected health information (PHI) about me to (list persons you give us authorization to communicate with via phone and/or email):

1) _____

2) _____

3) _____

This authorization permits NSC/3D to use and/or disclose individually identifiable health information regarding the patient to those identified above.

The Practice will ___ will not _X__ receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from NSC/3D. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the privacy officer at:

National Scoliosis Center/3-D Body Imaging, LLC
3023 Hamaker Court, Suite LL-50,
Fairfax, Virginia 22031

Office (703) 849-8808
Fax (703) 942-6062

Signed by: _____ _____
Signature of Patient or Legal Guardian Relationship to Patient

_____ _____
Print Patient's Name Date

_____
Print Name of Patient or Legal Guardian, if applicable

REVISED 05/2016