VALLEY MRI AND RADIOLOGY, INC.

STOCKTON (209)467-1000 LODI (209)366-1000

AUTHORIZATION

I authorize the release of any medical information necessary for treatment by my current or future physician or health care provider. I further understand that this information may be transmitted electronically.

Information disclosed pursuant to this authorization could be re-disclosed by the recipient. Such re-disclosure, in some cases, is not protected by California law and may no longer be protected by federal confidentiality law (HIPAA).

I authorize Valley MRI And Radiology, Inc. to release to my insurance company any medical information which may be necessary to process my insurance claim.

I authorize the release of information necessary to process this claim and assign benefits payable for services directly to Valley MRI And Radiology, Inc.

This assignment will remain in effect until revoked by me in writing.

A copy of this assignment is to be considered as valid as the original.

If I receive an insurance payment directly, I agree to make full payment immediately to Valley MRI And Radiology Inc.

I understand that in the event my insurance company denies this claim, I will be held financially responsible for all charges when applicable.

PATIENT:	**DATE:**

Signature: _____

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