BAY RADIOLOGY San Ramon
A Division of BASS Medical Group

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HIPAA Privacy Authorization Form
Authorization For Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

- I hereby authorize any insurance company, prepayment organization, employer, hospital, physician or utilization review representative to release to Bay Radiology San Ramon and the billing office of (BASS MEDICAL GROUP) all information with respect to me and/or my dependent(s) which may have a bearing on any benefits payable from my insurance company for the procedure(s) performed by the facility on me or my dependent(s).

- I hereby authorize Bay Radiology San Ramon and the billing office of (BASS MEDICAL GROUP) to release all information with respect to me and/or my dependent(s) which may have a bearing on either the procedure(s) provided or the benefits payable to me or my dependent(s): (I) to my insurance company, (II) to the physician or healthcare provider ordering/requesting the procedure(s), or (III) to Bay Radiology San Ramon and the billing office of (BASS MEDICAL GROUP) for the purpose of demonstrating the existence of obligations of a governmental, commercial, or other payer to pay Bay Radiology San Ramon and the billing office of (BASS MEDICAL GROUP) for services it performs on me or my dependent(s) behalf.

- I further consent and authorize Bay Radiology San Ramon and the billing office of (BASS MEDICAL GROUP) to release any medical information it deems necessary to ensure the continuity of my medical care to any subsequent treating physician or facilities without further written consent by me.

- I agree that this authorization shall remain in effective for one (1) year from the date indicated below.

_____

Print Patient Name

_____ _____

Patient / Guarantor / Responsible Party Signature Date