AUTHORIZATION FOR DISCLOSURE OF MEDICAL RECORD INFORMATION/WAIVER OF CONFIDENTIALITY

I understand that this information is the record of:

Name: _____ DOB: _____

Address: _____

And is personal and private. HOWEVER, I give my permission for:

1. Name: Open Air MRI of CenLA
   5413 Jackson Street Ext
   Alexandria, LA 71303
   (318)445-8009

To release this information to:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

The following specific information:

_____

_____

I understand that I have the right to refuse to disclose HIV test results.

____I DO NOT AUTHORIZE release of HIV test results.

The above listed information is to be released for the specific purpose of:

_____

I understand that my permission to release this information may be canceled at any time except when the information has already been released. My permission to release this information will expire: _____/_____/_____. I understand that the information disclosed by this authorization may be subject to re-disclosure by the recipient and is no longer protected by federal privacy regulations.

I undersigned certifies that he/she is the parent/guardian/ representative of the person listed above and has the legal authorization to sign on behalf of the person, whether by court order, or by operation of law.

Patient (Including Minor): _____ Date: _____

Parent or Guardian: _____ Date: _____

Witness: _____ Date: _____