Patient Disclosure Form

Name of the patient: ____________________________________________

I authorize and agree that Southwest Diagnostic Imaging, LTD., Scottsdale Medical Imaging, Valley Radiologists, LTD. and East Valley Diagnostic Imaging (together SDI) may disclose my protected health information to the following family member(s), friends or caretakers, each of whom is directly involved in my care.

1.________________________________________________________________

2.________________________________________________________________

3.________________________________________________________________

4.________________________________________________________________

☐ Do not speak with others about my protected health information

I acknowledge and agree that SDI may disclose my protected health information to the person set forth in this form unless and until I object to such disclosures, which must be provided in writing to SDI. I further acknowledge and agree that I am not required to complete or execute this form.

__________________________________________________________________
Signature of Patient or Patient's Personal Representative

__________________________________________________________________
Date

__________________________________________________________________
Print Name of Patient or the name of the Patient's Personal Representative