Patient Disclosure Form

Name of the patient: ____________________________________________

I authorize and agree that Southwest Diagnostic Imaging, LTD., Scottsdale Medical Imaging, and Valley Radiologists, LTD. (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 Patient's Personal Representative