BAY RADIOLOGY
San Ramon

Authorization for Use or Disclosure of Health Information and Consent to Release Information

Patient Account Number: _____

Print Name: _____ Date: _____

I hereby authorize any insurance company, prepayment organization, employer, hospital, physician, or utilization review representative to release to Bay Radiology San Ramon (the "Center") any and all information with respect to me or my dependent(s) which may have a bearing on any benefits payment by my insurance company for procedure performed by the Center.

I hereby consent and authorize the Center to release all information with respect to me or my dependent(s) which may have a bearing on either the procedure provided to the benefits payment to me or my dependent(s) (i) to my insurance company, (ii) to the physician or healthcare provider ordering/requesting the procedure, or (iii) to the Center's lender or its agents for the purpose of demonstrative the existence of obligation of a governmental, commercial or other payer to pay the Center for services it performs on my or my dependent's behalf.

I further consent and authorize the Center to release any medical information it deems necessary to ensure the continuity of my medical care to any subsequent treating physicians or facilities without further written consent by me.

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

Patient or Legal Representative Signature	Print Name (and Authority if Legal Representative)	Date