Irwin Grossman, M.D. · Medical Director
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HIPAA Authorization

Patient Name: ____
MRN: ___________________
DOB: ___________________

I,____________________________________, have been provided access to Grossman Imaging Center's Notice of Privacy Practices. I understand that I am entitled to a copy of these practices at my request.

I furthermore acknowledge that I have the right to designate access to my Protected Health Information (PHI) to anyone of my choosing. I hereby authorize disclosure of my PHI to the following individual(s):

Name:	Relationship:

I request the following restriction(s) to releasing my PHI:

I understand I may revoke this authorization anytime by submitting a written request to the GIC Privacy Officer, as per the office's Notice of Privacy Practices.

I understand that by signing this authorization, this information will be used by GIC to make determinations for the release of my PHI. I also understand this authorization will remain in effect until I request an update and/or amendment.

Signature of Patient (or Parent/Guardian) ____________________ Date/Time ____________________