

Thermal Image Analysis

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HIPAA Compliance Authorization of Electronic Transmission of Medical Data

I, the undersigned patient, hereby authorize the transmission of my medical thermography examination and corresponding health information to Thermal Imaging Analysis and Dr William Cockburn or his designated recipient for Interpretation and Report AND for the electronic return of this examination and its report to the laboratory or technician or physicians office who has performed the procedure,

I acknowledge that every attempt is being made by the designated lab and Thermal Image Analysis to comply with the Health Insurance Portability and Accountability Act (HIPPA) the primary goal of this form being to notify me of the actions being taken to protect my personal health information at both ends of this transmission.

I am advised via this form, that 1) the transmission of this data is being sent via 128 bit encryption software, 2) The Medical Data and Personal Health Information being transmitted and received (at both ends) uses PROPRIETARY SOFTWARE CODING only available to thermography labs and interpretation services whom I have agreed to allow the access of my Personal Health Information and 3) That special Sentinel Keys have also been issued to single users so that no other party can access the software which will open my Personal Health Information without legal authorization. Every effort will be made to protect your Medical Records and Personal Health Information.

I understand the above description of how my Medical Records and Personal Health Information will be transmitted and handled by the parties at each end of the electronic transaction and further agree that this form and any attachments thereto may be faxed to the secure fax of Thermal Image Analysis, acting as a consent to read and report on my thermographic examination.

Please Print Legibly

Patients Name Printed Clearly _____ Date _____

Patients Signature _____ Expires _____

For Thermography Laboratory Use Only

Name of Lab Sending This Authorization: Premier Acupuncture & Complementary Medicine, Inc.

Name of Authorized Individual Sending This Form: M. Newcomb J. McLain

Please Print Legibly