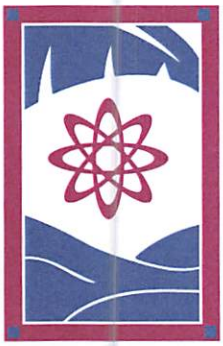
TEMECULA VALLEY

NUCLEAR MEDICINE
INC.



25485 Medical Center
Drive, Suite 102

Murrieta, CA 92562

951.698.4808
FAX 951.698.4805

HIPPA AUTHORIZATION FORM:

I _____DOB:_____ hereby authorize the use or disclosure of my protected health information as described below.

AUTHORIZED PERSONS TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION:

_____is authorized to disclose the following protected health information to:

Ernie Meth, M.D.
Temecula Valley Nuclear Medicine
25485 Medical Center Drive, Suite 102
Murrieta, CA 92562
(951) 698-4808 Phone
(951) 698-4805 Fax

DESCRIPTION OF INFORMATION TO BE DISCLOSED:

The health information to be disclosed is:

_____

All, Past, Present, and future periods of health information may be shared.

VALIDITY OF AUTHORIZATION FORM:

The Authorization is valid

beginning on _____

Expires on _____

ACKNLOWLEDGEMENT:

I understand the information used or disclosed under this Authorization form may be subject to re-disclosure by the person(s) of facilities receiving it and would then be no longer protected by federal privacy regulations.

I have the right to refuse to sign this Authorization form. If signed, I have the right to revoke this Authorization in writing at any time. I understand that any action taken in reliance upon this Authorization cannot be reversed, and my revocation will not affect those actions.

SIGNATURE: _____

DATE:_____