AURORA DIAGNOSTIC IMAGING, LLC

Consent for the Use and Disclosure of Protected Health Information

By signing below, you agree to the use and disclosure of your protected health information by Aurora Diagnostic Imaging, Robert Bridges, MD, our staff and other business associates for treatment, payment and healthcare operations.

For a more detailed description of uses and disclosures for these purposes, please review our **Notice of Privacy Practices**. You have the right to review our Notice prior to signing this consent. The terms of this Notice may change. If the terms do change, you may obtain a revised Notice simply by contacting 907-474-2002. We will also post any revisions of the Notice is our office.

You have the right to request that we restrict our uses or disclosures of your protected health information, which we are otherwise permitted to make, for treatment, payment and healthcare operations, although we are not required to agree to these restrictions. However, if we agree to these restrictions, they are binding on us. Finally, you have the right to revoke consent in writing, except to the extent that we have taken action in reliance on the consent.

AGREED and ACKNOWLEDGED

Signature____ Date__________________________

****

REVOCATION

Signature____ Date__________________________

2/28/08 mjc