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## Radiology Associates/AccuImaging–Data Release Authorization

In consideration of Radiology Associates/AccuImaging’s willingness to permit TeamPraxis to exchange, on my behalf and as my Business Associate, HL7 transactions with Radiology Associates/AccuImaging, I agree to accept full responsibility for their accuracy and propriety.

It is also understood that the appointment of TeamPraxis as my Business Associate shall remain in effect, and may be conclusively relied upon by you, until such time as you receive cancellation thereof executed in writing either by me or by TeamPraxis.

Provider Name:	_____
Contact Name:	_____
Contact Phone:	_____
Office Address:	_____ _____ _____
Provider Signature:	Date:
Leave field below blank – to be assigned by vendor	
PIN:	

**Complete form in full except for PIN. Fax back to 949-0483, ATTN TW SUPPORT**