Patient Consent To The Use & Disclosure Of Health Information For Treatment, Payment, Or Healthcare Operations

PLEASE PRINT. THANK YOU!

I, ________________________________, understand that as part of my health care, Choice Diagnostic Imaging originates and maintains paper and/or electronic records describing my health history, symptoms, examination and test results, diagnoses and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment,
- A means of communication among my healthcare providers,
- A source of information for business office and billing purposes,
- A means by which a third-party payer can verify that services billed were actually provided,
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals and a mechanism to communicate with persons regarding clinical research trials with which I participate.

I understand and have been provided with a Notice of Privacy Policies (Notice) that provides a more complete description of information uses and disclosures. I understand that I have the following rights and privileges:

- The right to review the notice prior to signing this consent,
- The right to object to the use of my health information for directory purposes, and
- The right to request restrictions as to how my health information may be used or disclosed to carry treatment, payment, or health care operations.

I understand that Choice Diagnostic Imaging is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that Choice Diagnostic Imaging reserves the right to change their notice and practices, in accordance with Section 164.520 of the Code of Federal Regulations.

I wish to have the following restrictions on the use or disclosure of my health information:

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I understand that as part of this organizations treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I fully understand and **accept / decline** the terms of this consent. (Circle **ONE**)

I authorize Choice Diagnostic Imaging to release information about my appointments, billing and/or financial information, and medical information to the following individuals:

CIRCLE ALL THAT APPLY: Spouse Parents Children Legal Guardian Grandparents

Other: ____
LIST BY NAME OR FACILITY NAME

Additionally, I authorize Choice Diagnostic Imaging to leave information concerning my appointments, billing or financial information, and medical information (strike through unacceptable options) on my answering machine/voice mail at the following phone number(s). I understand that receiving information regarding my health can be delayed if messages cannot be left.

________________________ ________________________
PHONE NUMBER PHONE NUMBER

I understand that in order to revoke the authorizations above (except to the extent that the organization has already), I must request this revocation in writing to the Privacy Officer and that until such written document is received, this authorization will be followed.

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PATIENT SIGNATURE *(GUARDIAN / PARENT IF A MINOR)* DATE