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Radiology Associates L.L.C.

# CONSENT TO THE USE AND DISCLOSURE OF HEALTH INFORMATION FOR TREATMENT, PAYMENT, OR HEALTHCARE OPERATIONS

NAME _____

BIRTHDATE _____ SOCIAL SECURITY #_____

I understand that as part of my healthcare, this organization originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment 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 the many healthcare professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- 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 care quality and reviewing the competence of healthcare professionals.

**I understand that I have the right:**

- To object to the use of my health information for directory purposes.
- To request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations – and that the organization is not required to agree to the restrictions requested.
- To revoke this consent in writing, except to the extent that the organization has already taken action in reliance thereon.

I have been presented with a copy of this provider's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning my personal medical information:

_____

_____

_____

**PATIENT:**

| _____ | _____ | _____ |
|---|---|---|
| Signature of Patient or Legal Representative | Date | Witness Signature |

**OFFICE USE ONLY:**

☐ Accepted

☐ Denied _____ _____ _____

Signature Title Date

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