OUTPATIENT IMAGING

## AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

By signing this authorization, I authorize OUTPATIENT IMAGING, LLC to use and/or disclose certain protected health information to or for the party or parties listed below:

This authorization permits OUTPATIENT IMAGING to use or disclose **Information and Results relating to the Imaging Studies Performed at OPI.**

**The purpose of this authorization is to "at the request of the individual", release information to the following**

**Parties/Doctors:**_____

_____

This authorization will expire on 6 years from initial date of signature.

I understand that I have the right to revoke this authorization. I understand that my revocation must be submitted in writing to **the Privacy Official at Ten Eastbrook Bend, Peachtree City, GA 30269.**

I understand that OUTPATIENT IMAGING may not condition treatment, payment, enrollment of eligibility for benefits on whether I sign this authorization.

X_____DATE_____

**PATIENT ACKNOWLEGEMENT OF NOTICE OF PRIVACY PRACTICES**

As required by the Privacy Standards of the Health Insurance Portability and Accountability Act of 1996(HIPAA)

I have received and/or have available a copy of the Notice of Privacy Practices on that date this form is signed. I understand that if any changes are made to this Notice of Privacy Practices, a revised copy will be posted in the office.

X_____DATE_____

## PATIENT AUTHORIZATION FOR INSURANCE AND RELEASE OF RECORDS

I authorize the release of any previous results or images in the event OUTPATIENT IMAGING, LLC, is in need of them to aid with the diagnosis of my procedure today. I permit a copy of this authorization to be used in the place of the original. Further more, I authorize payment directly from the patient's insurance company to Outpatient Imaging, LLC who provide radiology services to me. Where Medicare, Medicaid and Tricare (Champus) benefits apply, I certify that the information given me in applying payment under the Social Security Act is complete and correct and request that payment or authorized benefits be made on the patient's behalf. I authorize Outpatient Imaging, LLC to act as attorney-in-fact to collect and endorse payment checks from any payment source.

X_____

WITNESS X_____DATE_____