Radiology Associates of Venice and Englewood

DIPLOMATES AMERICAN BOARD OF RADIOLOGY

Patient Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I understand that as part of my healthcare, this practice originates and maintains paper and/or electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment, and 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 health professionals who contribute to my care, i.e. consultations & referrals
- A source of information for applying my diagnosis and treatment information to my bill, for payment purposes
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff

I have been provided the opportunity to review the *"Patient Privacy Practices"* that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the ***"Patient Privacy Practices"*** prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for purposes other than treatment or payment
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

_____

_____

If there is anyone you do not want us to discuss your healthcare information with, please list their names and relationship below

_____

_____

I understand that as part of treatment, payment, or healthcare operations, it may become necessary to disclose health information to another entity, i.e., referrals to other healthcare providers, labs, and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand the information provided by this consent.

_____	_____	_____
Signature	Print name of person signing	Date

*If other than patient is signing, are you the parent, legal guardian, custodian or have Power of Attorney for this patient, for treatment, payment or healthcare operations. Yes [ ] No [ ]

FOR OFFICE USE ONLY

[ ] Patient refused to sign the consent form.

[ ] Reason for patient refusal to sign _____

[ ] Restrictions were added by the patient (see restrictions listed above)

[ ] "Consent form" received and reviewed by _____ on (date) _____