More than just x-rays

Patient Name: _____ Date of Birth: _____

Mailing Address: _____ Marital Status: S M W D

City: _____ State: _____ Zip: _____

Phone #: _____ Cell phone: _____ SS #: _____

Email Address: _____

********** **Prior Records Release**********

Facility Name: _____

Phone#: _____ **Fax#** _____

****

PURSUANT TO AND AS REQUIRED BY THE PRIVACY REGULATIONS CREATED DUE TO HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA).

With my consent, Sugar Mill Diagnostic Imaging; may use and disclose *Protected Health Information (PHI)* about me to carry out *Treatment, Payment* and *Healthcare Operations (TPO).* A Complete Notice of Privacy is posted for a complete description of such uses and disclosures. I have the right to review the Notice of Privacy Practices at any time. A copy of a revised notice can be obtained at any time by forwarding a written request to this office.

By signing this form, I am consenting to Sugar Mill Diagnostic Imaging for the use and disclosure of my PHI to carry out TPO. I may revoke or restrict my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Sugar Mill Diagnostic Imaging will decline to provide treatment to me as they will be unable to carry out treatment, payment and healthcare operations without my consent.

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

Circle all that apply and list names:

Spouse Parents Children Legal Guardian Grandparents Other: _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN: _____ **DATE:** _____

How did you hear about this facility? Please circle all that apply

Sugar Mill Resident **Friend referred** **Dr. referred** **SMDI website** **Worker's Comp** **Facebook**

Other (Please Specify) _____