

**DIAGNOSTIC RADIOLOGY****CONSENT FORM****For Purposes of Treatment, Payment and Healthcare Operations**

I consent to the use or disclosure of my protected health information by Diagnostic Radiology (subsequently referred to as DR) for the purpose of diagnosing or providing treatment to me, obtaining payment for my healthcare bills or to conduct health care operations of DR. I understand that The Health Insurance Portability and Accountability Act of 1996 (HIPPA) does not require that I sign this Consent Form.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. DR is not required to agree to the restrictions that I may request. However, if DR agrees to a restriction that I request, the restriction is binding on DR and the radiologist.

I have the right to revoke this consent, in writing, at any time, except to the extent that the radiologist or DR has taken action in reliance on this consent.

My "protected health information" means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review DR's Notice of Privacy Practices prior to signing this document. DR's Notice of Privacy Practice has been provided to me. The Notice of Privacy Practice describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of DR. The Notice of Privacy Practice for DR is also visibly posted in their office. This Notice of Privacy Practice also describes my rights and DR's duties with respect to my protected health information.

DR reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

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*Signature of Patient or Personal Representative*

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*Print Name of Patient or Personal Representative*

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*Date*

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*Description of Personal Representative's Authority*