The Radiology Clinic, LLC
Sign In

Name_____
Last First MI

Mailing Address _____

City_____ State _____ Zip _____

E-mail_____

Can we email you our monthly newsletter? ❒ Yes ❒ No

Date of Birth _____ Social Security # _____-_____-_____

_____ _____ _____
Primary Phone Secondary Phone Work Phone

Which should we call first? ❒ Primary ❒ Secondary ❒ Work

May we leave a voicemail or text message on your phone? ❒ Yes ❒ No

Date _____ Patient Signature _____

Insured's Place of Employment_____

Responsible Party (if other than patient)

Name_____
Last First MI

Mailing Address _____

City_____ State _____ Zip _____

Date of Birth _____

Acknowledgment of Receipt of Notice of Privacy Practices

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices of The Radiology Clinic.

_____
Patient Name (Print)

_____ _____
Signature of Patient or Legal Representative Date

The Radiology Clinic

Patient Authorization for Use and/or Disclosure of Protected Health Information

Patient Name:	Date of Birth:
Address:	Social Security or Account Number:

I hereby authorize The Radiology Clinic, LLC ("Radiology Clinic") to use, disclose and/or obtain the above-named patient's health information as follows (*check all that apply*):

□ **use the following health information maintained by Radiology Clinic until:**	□ **disclose the following health information to**:	□ **obtain the following health information from:**
_____ **Expiration Date/ will expire one year from signed date unless otherwise specified above.**	_____ **Address**:_____ **City, State, Zip**:_____ **Phone**:_____	_____ **Address:**_____ _____ _____

Specific description of the health information to be used/disclosed/obtained (*include dates of service, i.e., appointment date, type of service, etc):*_____
_____
_____

This health information is used/disclosed/obtained for the following purpose (*if Authorization requested by the patient put: "At the request of the individual"*): _____
_____

By providing this Authorization, I understand as follows:

1. **I understand that this Authorization may result in the sending of clinical information and x-rays with reference to the above-named patient's diagnosis and/or any alcohol, drug or child abuse problems, behavioral or mental health services, and/or information concerning sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency syndrome (HIV). I understand that these records are strictly confidential and are solely for the information of the person to whom addressed.**
2. I understand that this Authorization is voluntary. I may refuse to sign this Authorization and the above-named patient's treatment and/or payment obligations will not be affected unless either of the following applies:
   - The treatment is related to research and the use and/or disclosure is related to such research; or
   - The treatment is solely for the purpose of creating protected health information for disclosure to a third-party.
3. I understand that Radiology Clinic will not receive financial or in-kind compensation or remuneration in exchange for the use and/or disclosure of the above-named patient's protected health information unless an applicable legal exception applies.
4. I understand that the health information to be released may be subject to redisclosure by the recipient of the health information and no longer protected by federal or state law.
5. I understand that this Authorization is continuous in nature and is to be given full force and effect, including disclosing and/or utilizing any and all of the foregoing information learned or determined after the date hereof but prior to the expiration date noticed below.
6. I understand that I may revoke this Authorization at any time by notifying Radiology Clinic in writing, but if I do, it will not have any effect on uses or disclosures prior to the receipt of the revocation. Unless otherwise revoked, this Authorization will expire on _____ (date, event, or condition). If I fail to specify a date, event, or condition, this Authorization will expire in one (1) year.
7. I understand that, upon request, I may receive a copy of this Authorization form after I sign it.
8. I understand that a photocopy or facsimile of this Authorization shall be valid and effective, just as the original.

_____ _____
Signature of Patient of Patient's Representative Date

_____
Printed Name of Patient's Representative (if applicable)

_____
Representative's Relationship to Patient (if applicable)