77 W. Forest Ave., Ste. 101, Flagstaff, AZ 86001

Patient Consent for Use/Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name (if applicable): _____

I understand that my/the patient's health information is private and confidential. I understand that Northern Arizona Radiology works hard to protect my/the patient's privacy and preserve the confidentiality of my/the patient's personal health information. I understand the Northern Arizona Radiology may use and disclose my/the patient's health information to provide treatment to me/the patient, to handle billing and payment, and to take care of other healthcare operations. In general, there will be no other uses and disclosures of this information unless I/the patient permit it. I understand that sometimes the law may require the release of this information without my permission. These situations are very unusual, but one example would be if a patient threatened to hurt someone.

Northern Arizona Radiology has a detailed document called the "Notice of Privacy Practices". It contains more information about how we may use and disclose patient health information. I understand that I have a legal right to read the "Notice" before I sign this consent.

Northern Arizona Radiology may update the "Notice of Privacy Practices". If I ask, Northern Arizona Radiology must provide me with the most current "Notice".

Under the terms of this consent, I can ask Northern Arizona Radiology to restrict how my/the patient's protected health information is used or disclosed to carry out treatment, obtain payment, or other healthcare operations. I understand that Northern Arizona Radiology does not have to agree to my/the patient's request if it interferes with any of the above.

I may cancel this consent at any time by writing, signing and dating a letter to Northern Arizona Radiology. If I write a letter, it must specifically state that I want to revoke my/the patient's consent for authorization to use/disclose health information for treatment, payment, and other healthcare operations.

If I revoke this consent or do not agree to sign this consent form, Northern Arizona Radiology does not have to provide any healthcare services to me/the patient.

My signature below indicates that I have been given the option to read and review a current copy of Northern Arizona Radiology's "Notice of Privacy Practices". My signature means that I agree and consent to allow Northern Arizona Radiology to use/disclose my/the patient's protected health information to carry out treatment, obtain payment, and any other additional healthcare operations.

_____ _____

Patient or legally authorized individual signature Date

Relationship to patient if signed by anyone other than the patient: _____