NOTICE OF PRIVACY PRACTICES (HIPAA) – MEDICAL RECORD RELEASE

Patient's Name: **[PATIENT NAME]** DOB: **[DOB]** ID#: **[ID#]**

- I hereby acknowledge I have been offered a copy of Radiology Associates' **NOTICE OF PRIVACY PRACTICES**.
- I further acknowledge that a copy of the current notice is posted in the reception area and it is available on Radiology Associates' website: ***www.rasloimaging.com***.
- As indicated in the **NOTICE OF PRIVACY PRACTICES**, I acknowledge that Radiology Associates may disclose and / or request my medical records to assist in my treatment and continuity of care.
- As indicated in the **NOTICE OF PRIVACY PRACTICES**, I acknowledge that I have the right to request a copy of my medical records.
    - I understand that I will be charged **$15.00** per sheet of film requested and / or **$15.00** per CD.
    - I further understand that I am to obtain a copy of my imaging report from my referring physician so that they may review it with me and answer any of my questions.
    - If I have not been successful in obtaining my report in a minimum of 3 days after my exam, Radiology Associates will provide a copy to me at my request. I understand that any questions I may have regarding my results must be directed to and answered by my referring physician and not Radiology Associates. Many physicians request that release of results come directly through their office.

RELEASE OF PRIOR IMAGING STUDIES AND REPORTS

Digital Medical Imaging	PH: (805) 296-3546	FAX: (805) 296-3547	522 E. Plaza Dr., Santa Maria, CA 93454
Five Cities Medical Imaging	PH: (805) 296-3546	FAX: (805) 296-3547	921 Oak Park Blvd., Ste. 102, Pismo Beach, CA 93449
Radiology Diagnostic Center	PH: (805) 296-3546	FAX: (805) 296-3547	1310 Las Tablas Rd., Ste. 103, Templeton, CA 93465

☐ **PLEASE MAIL ALL PRIOR REPORTS AND IMAGES TO 1310 LAS TABLAS RD., STE 103, TEMPLETON, CA 93465**

All studies can be eMixed using emix@ra-slo.com

- I authorize the following (listed below) to **release / receive** medical information **to / from** the facility checked above:

Name: ____ Phone: ______________________

Address: ____ Fax#: ______________________

____

☐ All imaged data and reports ☐ Permanent release of mammography records

☐ Specific study(ies): ______________________________ From _________________ to ___________________

RELEASE OF MY MEDICAL RECORDS TO THIRD-PARTY

- I further authorize the disclosure of my radiology medical records from any Radiology Associates' outpatient imaging center to the following individual(s):

  Name: ____

  Relationship: Spouse / Child / Parent / Other_______________________

This authorization can be revoked at any time with written notification.

____ ___________________________

Patient (or Legal Guardian) Signature *Date*