Privacy Consent- For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to BMX Imaging Center to use and disclose my protected health information for the purposes of treatment, payment and operations of my healthcare and this practice.

Consent for treatment: With my signature, I authorize BMX Imaging Center, its Affiliates and any employee working under the direction of the physician to provide treatment, for the purpose of evaluating my health and diagnosing medical condition.

Consent for payment and operations: I also authorize this practice to furnish my health information as needed to obtain payment for my health care services. This may include certain activities that my insurance plan may undertake before it approves or pays for health care services BMX Imaging Center recommends, such as: making determination of eligibility or coverage for insurance benefits, reviewing services provided to me for medical necessity, and undertaking utilization review activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care. I Understand that these records are protected by the Code of Federal Regulations Title 43 Part 2 (42 CFR Part2) which prohibits the recipient of these records from making any further disclosers to the third parties without the express written consent of the patient.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice Privacy Officer by phone or writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Patient Name Printed _____ DOB: _____

Guardian Name Printed (if Applicable): _____

Patient/Guardian Signature: _____Date:_____

If not Patient, relationship: _____

Patient unable to sign due to: _____ Refusal to sign Date: _____

Revised CD 02/22/11

PATIENT CONFIDENTIALITY

PATIENT NAME: _____ Date of Birth: _____

To ensure the confidentiality of all our patients, it is the policy of our offices to release information regarding each patient only to the patient. If you wish for others to receive information regarding your care, you must sign this release. By signing this, you are giving our office staff permission to release information to your insurance companies, any necessary treating physician, therapist, hospitals, or outpatient services.

If you would like us to release patient information to someone other than those mentioned above, please list their names, phone numbers, and relationship to you. This may include spouse, children (not minors), parents, etc.

NAME	PHONE NUMBER	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

When trying to reach you by telephone, do we have permission to leave a message regarding your medical care or test results on your home answering machine/voice mail? ☐ Yes ☐ No
Phone Number _____

May we reach you at work? ☐ Yes ☐ No Work Number _____

May we call your cell? ☐ Yes ☐ No Cell Number _____

May we send you a text message? ☐ Yes ☐ No

May we leave a message on your cell? ☐ Yes ☐ No

Where do you prefer to be called? _____

I understand by signing this form, I have authorized this practice to release my medical information.

_____ _____
Patient Signature Date

1069 Delaware Avenue Suite 104B - Marion, Ohio 43302 - (740)751-6828 - Fax (740)751-6829

PATIENT CONFIDENTIALITY-MINORS

PATIENT NAME: _____ Date of Birth: _____
PLEASE PRINT

Parent with Custody: (. .) Names: _____

Other Parent, if separated: _____
Is this parent allowed medical information/treatment? ☐ Yes ☐ No

To ensure the confidentiality of all our patients, it is the policy of our offices to release information regarding each patient only to the patient and/or parent or guardian. If you wish for others to receive information regarding patient care, you must sign this release. By signing this, you are giving our office staff permission to release information to your insurance companies, any necessary treating physician, therapist, hospitals, or outpatient services.

If you would like us to release patient information to someone other than those mentioned above, please list their names, phone numbers, and relationship to you.

Please include adults that may bring minor child to office for treatment. Ex: Grandparents or Step-Parents.

NAME	PHONE NUMBER	RELATIONSHIP
_____	_____	_____
_____	_____	_____
_____	_____	_____

When trying to reach you by telephone, do we have permission to leave a message regarding patient medical care or test results on your home answering machine/voice mail? ☐Yes ☐ No
Phone Number _____

May we reach parent at work? ☐ Yes ☐No Parent _____ Work Number _____

May we call parent's cell? ☐Yes ☐ No Parent _____ Cell Number _____

May we leave a message on parent's cell? ☐Yes ☐ No

May we send you a text message? ☐Yes ☐ No

Where do you prefer to be called? _____

I understand by signing this form, I have authorized this practice to release patient medical information.

_____ _____
Legal Guardian Signature Date

***Please be aware that sexual health procedures and test results will only be discussed with the patient.**

Mammography Department

CONSENT FOR MAMMOGRAPHY & PATIENT ADVISORY

Mammography is currently the most accurate method to detect breast cancer. However, Mammography does not detect all breast lumps or breast cancers, and breast ultrasound does not detect all solid masses or breast cancers. A monthly self-breast exam as well as an annual breast exam by a qualified health care practitioner is recommended. Note: If you have not had a recent breast exam by your physician or nurse practitioner, we recommend that you do so.

If you have breast implants, please advise the technologist, as breast implants require a special type of exam that includes more pictures than mammograms done on women without implants. This is because the implant obscures some of the breast tissue and can make interpretation more difficult. As with all mammograms, some compression is necessary to obtain the best exam possible. In pictures with implants, compression will be used to attempt to prevent motion from occurring which could blur/degrade the image. To see the breast tissue in front of the implant, compression will be applied, possibly causing some discomfort for a few seconds as can be the case with any mammogram. Problems caused by compression or moving the implant are rare but cannot be excluded, especially for older or weakened implants. It is not unusual for an implant rupture that was not felt by you or by your physician to first be noticed on mammogram. Since this risk of rupture caused by the mammogram procedure is very low and the risk of breast cancer is greater, we hope you understand the benefit of early detection and proceed with your mammogram.

By signing below, I certify that (a) I have read this document; (b) I understand the risks and hazards outlined herein and the extent of my authorization being provided by signing below, (c) I have been given an opportunity to ask questions about the procedure and the information contained in this document and any such questions have been answered to my satisfaction, and (d) I believe I have sufficient information to give this informed consent. I voluntarily consent and authorize BMX Imaging Center to perform my mammography exam.

PATIENT'S SIGNATURE:_____

D.O.B.:_____ TODAY'S DATE: _____

X-Ray/Ultrasound Patient Consent Form

Patient Consent to X-Ray/Ultrasound

I authorize the performance of diagnostic x-ray and/or ultrasound examination of myself which my physician may consider necessary or advisable in the course of my examination and treatment.

Patient's Signature: _____ Date _____

Printed Name: _____ Date of Birth: _____

If Patient is a Minor:

I am the parent or legal representative of _____ who is a minor, _____ years of age. I authorize the performance of diagnostic x-ray and/or ultrasound of this minor which my physician may consider necessary or advisable.

Signature of Parent/Guardian: _____Date: _____

_____
Relationship to Patient

Females:

Regarding Possibility of Pregnancy:
This is to certify that, to the best of my knowledge, I am not pregnant, and BMX Imaging, LLC has my permission to perform diagnostic x-ray examination. I have been advised that certain x-ray examinations, particularly those involving the pelvis, can be hazardous to an unborn child.

Patient's Signature: _____ Date: _____

Printed Name: _____ Date of Birth: _____