

Patient Authorization

Section I : Receipt Acknowledgement for the Notice of Privacy Practices

I, _____ have been made aware of the notice of Privacy Practices for Envision Radiology, dba as Envision Imaging, Health Images and Colorado Springs Imaging and further referred to as "Envision Radiology." I understand that this notice states how Envision Radiology may use and disclose my Protected Health Information ("PHI.")

I UNDERSTAND THAT A COPY OF THIS NOTICE IS AVAILABLE UPON REQUEST.

_____Initial

Section II: Consent for Treatment

I authorize Envision Radiology, to perform all exams, tests, procedures, injections and any other care deemed necessary or advisable for the diagnosis and treatment of my medical condition(s.)

_____Initial

Section III: Consent for Release & Acquisition of Medical Records

In order to provide the most accurate reading of my current studies and to assure that I am receiving the highest quality of care, I consent to Envision Radiology obtaining any of my previous images, radiology reports, pathology reports, or results of surgical intervention for comparison to my current studies and to track abnormal results. For the same purpose, Envision Radiology may release my studies performed at an Envision Radiology facility to my treating physicians and medical facilities, upon their request.

In order for Envision Radiology to obtain and release my records in a timely manner, I authorize Envision Radiology to convey my records and images by Certified Mail, Courier or Electronic Transmission.

_____Initial

Section IV: Release of Records to a Designated Third-Party

In addition to my treating physicians and medical facilities, I authorize Envision Radiology to release my records and images to the following individuals. (This should include **friends or family members** responsible for picking up your records when you are unable to do so.) PLEASE PRINT

Name: _____

Phone: _____

Name: _____

Phone: _____

_____Initial

Patient Signature:

By signing below I am verifying that I have read each of the four sections on this page. I understand each section and consent to and agree with the information stated in each section.

Patient / Legal Representative Signature

Date

Patient's Printed Name

Date