



**PATIENT INFORMATION: (Please Print)**

Patient First Name \_\_\_\_\_ MI \_\_\_\_\_ Last Name \_\_\_\_\_

Date of Birth \_\_\_\_\_ SS # \_\_\_\_\_ Sex \_\_\_\_\_

Home Phone # \_\_\_\_\_ Cell # \_\_\_\_\_

Mailing Address \_\_\_\_\_

City \_\_\_\_\_ State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

Email Address: \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

Marital Status: (Please circle one)    Single    Married    Divorced    Widowed    Separated

**PERSON TO CONTACT IN CASE OF EMERGENCY:**

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

Name \_\_\_\_\_ Phone # \_\_\_\_\_ Relationship \_\_\_\_\_

**SUBSCRIBERS INFORMATION:**

Name of Policy Holder: \_\_\_\_\_ Relationship to patient: \_\_\_\_\_

Date of Birth \_\_\_\_\_ Social Security # \_\_\_\_\_

Address (if different from patient) \_\_\_\_\_

Phone Number (if different from patient) \_\_\_\_\_

Employer \_\_\_\_\_ Work Phone # \_\_\_\_\_

**MINORS ONLY-Parent's Information:**

Father's Name \_\_\_\_\_ Phone # \_\_\_\_\_

Mother's Name \_\_\_\_\_ Phone # \_\_\_\_\_

**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES FOR IMAGING CENTER OF IDAHO,  
VEIN CENTER OF IDAHO AND ADVANCED OPEN IMAGING CENTER**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

By signing below, I am acknowledging that: I am either the patient or the patient’s personal representative; I have been offered a copy of the “Notice of Privacy Practices” (NPP); and I understand that I may contact the person named in the NPP if I have questions about the consent.

\_\_\_\_\_ I have requested a hard copy of the NPP.

\_\_\_\_\_  
Signature of patient or parent/legal guardian/legally responsible for person Date

\_\_\_\_\_  
Description of relationship to patient

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**CONSENT FOR USE AND DISCLOSURE OF HEALTH INFORMATION**

Purpose of consent by signing this form, you will consent to our use and disclosure of your protected health information (PHI) to carry out treatment, payments and healthcare operations.

Notice of Privacy Practices: You have the right to read our Notice of Privacy before you decide whether to sign this consent. Our notice provides a description of our Treatment, Payments and Healthcare Operations; it also describes the uses and disclosure we may make of your protected health information and of other important matters about your protected health information.

We reserve the right to change our privacy practices as described in our Notice of Privacy Practices. If we change our practices, we will issue a revised Notice of Privacy Practices, which will contain the changes. Those changes may apply to any of your PHI that we maintain.

Right to revoke: You will have the right to revoke this consent at any time by giving us written notice of your revocation submitted to the Contact Person in our office. Please understand that revocation of this consent will not affect any action we took in reliance on this consent before we received your revocation.

I have had full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form, I am giving my consent for you to use and disclose my PHI to carry out Treatment, Payments and Health Care Operations.

I hereby give my consent to release my Health information to the following people:

- Family or Friends you give us permission to discuss/release your PHI to.**
1. \_\_\_\_\_
  2. \_\_\_\_\_
  3. \_\_\_\_\_

I hereby give consent to leave a detailed message on the following phone #: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

If this consent is being signed by a personal representative on behalf of the patient please complete the following:

Personal Representative’s Name: \_\_\_\_\_ Relationship to Patient: \_\_\_\_\_

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**REVOCAION OF CONSENT**

I revoke my consent for your use and disclosure of my PHI. I understand that my revocation of my consent will not affect any action you took in reliance on my consent before you received this notice.

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

***This will stay in effect until and unless you revoke the consent.***



4519 Enterprise Way  
Caldwell, Idaho 83605  
Phone: 208-455-7482  
Fax: 208-455-7538

## AUTHORIZATION TO RELEASE MEDICAL RECORD INFORMATION

PATIENT NAME: \_\_\_\_\_ DATE OF BIRTH: \_\_\_\_\_

AKA'S (Also Known As): \_\_\_\_\_

Address \_\_\_\_\_ Phone \_\_\_\_\_

City \_\_\_\_\_ State \_\_\_\_\_ Zip \_\_\_\_\_

### MAMMOGRAPHY PATIENTS ONLY:

Date of Prior Exams (**US Breast, Mammogram or MRI Breast**): \_\_\_\_\_

Name of Facility where exam was performed: \_\_\_\_\_

Date of service \_\_\_\_\_

To \_\_\_\_\_

\_\_\_\_\_

Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

PICKUP

MAIL

FAX

COURIER

MAMMOGRAPHY

CT

MRI

XRAY

US

DEXA

\_\_\_\_ FILMS

\_\_\_\_ REPORT

\_\_\_\_ SURGERY REPORT

\_\_\_\_ PATHOLOGY REQUEST

X \_\_\_\_\_

Patient/Guardian Signature

Witness Signature

Relationship to Patient

Date/Time