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 my 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

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:

1. _____
2. _____
3. _____

Family or Friends you give us permission to discuss/release your PHI to.

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:_____

REVOCATION 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