CHATTANOOGA CLEVELAND
IMAGING

AND
ASSOCIATES IN DIAGNOSTIC RADIOLOGY, P.C.
CONSENT FORM

A current copy of the Notice of Privacy Practices is posted in the reception area. A copy of Privacy Practices will be provided upon request. The Notice of Privacy Practices may change at any time. Changes will apply to all health information obtained by Chattanooga Imaging.

I acknowledge that I have been provided the opportunity to review the Notice of Privacy Practices for Chattanooga Imaging and Associates in Diagnostic Radiology.

Patient Signature _____

I authorize the following person(s) to receive/request my private health information:

_____
(Name and Relationship)

_____
(Name and Relationship)

_____
(Name and Relationship)

Patients have the right to request a restriction to whom their private health information is disclosed. Requests for restrictions will be submitted to the Administrator for review. Chattanooga Imaging and Associates in Diagnostic Radiology reserve the right to deny any requests. If your request is denied, you will be notified in writing within 30 days. You then have the right to revoke your consent in writing to the extent it hasn't already been relied upon.

I authorize Chattanooga Imaging and Associates in Diagnostic Radiology to use or disclose my private health information for the purposes of treatment, payment or health operations. I authorize and consent to the tests, procedures, and medical treatment deemed necessary and applicable by my physician(s), his/her designees, Chattanooga Imaging and Associates in Diagnostic Radiology.

I authorize Chattanooga Imaging to release to the Social Security Administration, its intermediaries or its carriers, any medical or other information needed for this or other related Medicare claim. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. In assigned cases, the doctor agrees to accept the charge determination of the Medical carrier as the full charge for covered services. The patient is responsible only for the deductable, co-insurance, and non-covered services.

I understand that I am responsible for payment to both Chattanooga Imaging and Associates in Diagnostic Radiology.

Patient Signature _____

Witness Signature _____