Radiology Associates

NOTICE OF PRIVACY PRACTICES (HIPAA) – MEDICAL RECORD RELEASE

Patient's Name: DOB: ID#:

- I hereby acknowledge I have been offered a copy of Radiology Associates' **NOTICE OF PRIVACY PRACTICES**.
- I further acknowledge that a copy of the current notice is posted in the reception area and it is available on Radiology Associates' website: ***www.rasloimaging.com*.**
- As indicated in the **NOTICE OF PRIVACY PRACTICES**, I acknowledge that Radiology Associates may disclose and / or request my medical records to assist in my treatment and continuity of care.
- As indicated in the **NOTICE OF PRIVACY PRACTICES**, I acknowledge that I have the right to request a copy of my medical records.
    - I understand that I will be charged **$15** per sheet of film requested, **$15** per CD, and/or **$10** per imaging report.
    - I further understand that I am to obtain a copy of my imaging report from my referring physician so that they may review it with me and answer any of my questions.
    - If I have not been successful in obtaining my report in a minimum of 3 days after my exam, Radiology Associates will provide a copy to me at my request. I understand that any questions I may have regarding my results must be directed to and answered by my referring physician and not Radiology Associates. Many physicians request that release of results come directly through their office.

☐ I authorize Radiology Associates to obtain all prior and future medical records pertaining to my imaging

Patient Initials

Outside Facility: Please send all **IMAGES** (on a CD) and **REPORTS** to Radiology Associates
1310 Las Tablas Rd, Suite 206, Templeton, CA 93465, Fax #805-296-3547
All studies can be eMixed using emix@ra-slo.com

AUTHORIZATION FOR ADDITIONAL PERSON(S) ACCESS TO RECEIVE/OBTAIN YOUR MEDICAL RECORDS ON YOUR BEHALF:

I further authorize the disclosure of my radiology medical records from any Radiology Associates' outpatient imaging center to the following individual(s):

Name: _____ Relationship: Spouse / Child / Parent / Other_____

This authorization can be revoked at any time with written notification.

_____ _____

Patient (or Legal Guardian) Signature *Date*

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Radiology Associates

Health Companion®
Your Personal Health Network SM

HEALTH COMPANION DATA SHEET

Great News! You can now access your imaging results online at NO extra cost.

Patient Name:		DOB:
Visit Date:	Social Security:	
(Email required to receive reports)	Email:	

1. **Go to:**
   www.HealthCompanion.com/ehr/00490

   You must enter the **/ehr/00490 portion of the web address to link to Radiology Associates*

2. You will need to enter your PIN if you have not already established a link between your Health Companion account and us.

3. **Your PIN is:**

What is Health Companion? It's a free, secure, and confidential, personal health record to help you store information and live a healthier life. For questions related to your Health Companion account contact Health Companion Support: at 1-866-944-8196 or support@healthcompanion.com

What if my record isn't available when I log-on? Try again in a day or two. Imaging reports will come after **3 days** to allow your referring physician time to review them first.

What if I don't register? Your personal access to the information we are providing you will expire in **30 days** if you don't complete your registration.

After you sign up for Health Companion: Use Health Companion to manage your health information. If you desire, upload your other healthcare records. Track your prevention needs, screening exams, and healthy habits. Invite friends and family to join and communicate about health issues with others, WITHOUT sharing your personal health information.