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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