Print

Charleston Radiologists, PA

Authorization of Use and Disclosure of Protected Health Information

Appointment Reminders.
The practice may use your information to remind you about upcoming appointments. Typically, appointment reminders are sent by mail in a sealed envelope, or, a brief, nonspecific message may be left on your answering machine. Occasionally, we may also use "appointment cards" to remind you about upcoming appointments. If you don't approve of these methods and would like alternative reminder methods (i.e., email) please indicate those methods in the space provided (samples of appointment reminders are available upon request):

How would you like to be contacted regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Charleston Radiologists, PA (Check all that apply)

___Regular Mail ___ Home Telephone ___ Work Telephone
___Appointment Cards ___ Email ___ Home Fax Machine

Other:_____

If you have an answering machine, may we leave messages regarding appointments, treatment and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Charleston Radiologists, PA (Check one)
___YES ___ NO ___N/A

If "NO", how else may we contact you regarding this information?

Please list any other restrictions regarding messages or reminders about your healthcare:

Other Uses and Disclosures. Disclosure of your health information or its use for any purpose other than those listed in the "Notice of Privacy Policies and Practices" brochure and I or consent requires your specific written authorization. If you change your mind after authorizing a use or disclosure of your information you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restrictions on use and disclosure of your health information.

____ I would like the following restrictions regarding the use and disclosure of my health information:

Charleston Radiologists, PA

Persons Authorized to Receive Information:

Health information Charleston Radiologists collects or receives about you may be disclosed to the following persons:

_____

Name of person / relation / organization

_____

Name of person / relation / organization

Use and Disclosure of Information:

___ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other information pertinent to my healthcare and/or payment for my healthcare provided at Charleston Radiologists, PA.

___I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please specify):_____

Expiration Date of Authorization

This authorization is effective through ___/___/___ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to Charleston Radiologists, PA. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-disclosure

The person or organization to which health information is sent may repeatedly disclose health Information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

_____

Name of Patient (Print or Type)

_____ _____

Signature of Patient Date

_____

Signature of Patient Representative

_____

Relationship of Patient Representative to Patient