Impression:Imaging
CT•PET•CTA

HIPAA FORM

Patient Name: _____ DOB:_____ MRN#:_____

This notice describes how medical information about you may be used and disclosed and how you can get access to this information. Please review it carefully. If you have any questions about this notice please contact Impression Imaging LLC at 954-580-2780.

WHO WILL FOLLOW THIS NOTICE

This notice describes information about privacy practices followed by our employees and staff. The practices describes in this notice will also be followed by health care providers you consult with by telephone who provide "call coverage" for your health care provider.

YOUR HEALTH INFORMATION

This notice applies to the information and records that we have about your health, health status, and the health care services you received at this facility. We are required by law to give you this notice. It will tell you about the ways in which we may use and disclose health information about you and describes your rights and our obligations regarding the use and disclosure of that information.

HOW WE MAY USE AND DISCLOSE HEALTH INFORMATION ABOUT YOU

We must have your written, signed consent to use and disclose health information for the following purposes:

For Treatment: We may use health information about you to provide you with medical treatment or services. We may disclose health information about you to your doctors, nurses, technicians, office staff, or other personnel who are involved in taking care of you and your health. Different personnel in our office may share information about you and disclose information to people who do not work in our facility in order to coordinate your care. Family members and other health care providers may be part of your medical care outside this facility and may require information about you that we have on file.

For Payment: We may use and disclose health information about you so that the services you receive at this facility may be billed to and payment may be collected from you, an insurance company or a third-party. We may also tell your health plan about any other diagnostic test necessary of obtain prior approval, or to determine whether your plan will cover the treatment.

AUTHORIZATION FOR INSURANCE PAYMENT

I, _____, authorize any holder of medical or other information about me to release my Insurance carrier(s) or to the billing agent of Impression Imaging, any information needed for this or related claims. 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.

I have been provided with a notice of Privacy Practices of Impression Imaging LLC that HIPAA outlines what will be done with my Protected Health Information.

PRINT PATIENT'S NAME	PATIENT SIGNATURE	DATE
GUARANTOR/GUARDIAN NAME	SIGNATURE OF OTHER	DATE
WITNESS		DATE