Advanced Imaging Center

Notice of Privacy Practices Patient Acknowledgement Form

Patient Name: _____ Date of Birth: _____

I have received this practice's Notice of Privacy Practices written in plain language. The Notice provides in detail the uses and disclosures of my protected health information that may be made by this practice, my individual rights and the practice's legal duties with respect to my protected health insurance.

Advanced Imaging Center has implemented the following to protect and safeguard my health information:

- -Ongoing training for all employees on privacy policies and procedures
- -Established safeguards to protect all electronically stored data

Advanced Imaging Center will only use my personal information for

- -Planning care and retreat
- -Communication with other health care professionals who may contribute to my care
- -Communication with my insurance provider

Advanced Imaging Center does request my permission to have a

- -Sign-in sheet at the front desk
- -To call my daytime phone number to confirm my appointment
- -To call out my name at the time of my appointment

Advanced Imaging Center will get my written permission if they were to use my personal information for any other reason other than the minimum necessary. My individual rights with respect to protected health information provides me with the right:

- -To revoke this consent in writing, except to the extent that **Advanced Imaging Center** has already taken action in reliance thereon
- -To inspect, amend, request restrictions in writing, get a copy of my medical information, and information about the disclosures they have made on my behalf
- -To complain to this practice and to the Secretary of HHS if I believe my privacy rights have been violated, and that no retaliatory actions will be used against me in the event of such a complaint

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By signing this agreement, I have read and understood this practice's Notice of Privacy Practices. Please do not hesitate to contact our privacy officer, at (661) 949-8111 if you have any questions, concerns or suggestions.

_____ _____

Signature of Patient or Legal Representative Witness Date

Advanced Imaging Center

AUTHORIZATION FOR DISLOSURE OF PROTECTED HEALTH INFORMATION

Please complete this form in its entirety. Items not checked or blanks unfilled are assumed to be nonapplicable or specifically not authorized for release. This release is not valid if it does not contain the patient's original signature and date signed or if it has expired as described below. A copy of this signed form will be provided to the patient.

I hereby authorize (name of provider/address):
Advanced Imaging Center

To disclose the following information from the health records of:

Name: _____
Last First MI Previous Name
Birthdate: _____ Social Security Number: _____
Telephone: (H)_____(W)_____
Address: _____
Street City State Zip

This information is to be disclosed to:

Covering the periods of healthcare (Date(s) of service):

From (date)_____To (date)_____

For the purpose of: _____
(Not required if the disclosure is requested by the patient)

The following information my be released:

I understand that this will include information relating to (check and initial, if applicable):
Acquired immunodeficiency syndrome (AIDS) human immunodeficiency virus (HIV) infection
Behavioral health service/psychiatric care
Treatment for alcohol and/or drug abuse

If compensation will be received: I understand that Advanced Imaging Center will receive compensation for its use/disclosure of the information release pursuant to this authorization. Patient's initials: _____

Affirmation of Release:
I give Advanced Imaging Center or the named agency permission to release only the information I have selected on this form to the individual(s) or agency(s) I have named and only for the purposes I have checked. I understand that this release is valid up to one year from the date I sign it and I may refuse to sign this authorization or revoke this authorization at any time. Any revocation or refusal to sign this authorization will not affect my ability to obtain treatment or payment or my eligibility for benefits. The revocation will take effect on the day it is received in writing. As a patient I have the right to access my treatment records during hospitalization and after discharge. Copies of the records may be obtained with reasonable notice and payment of copying cost. I further understand that if the person or entity that receives the above specified information is not a health care provider, health plan or health care clearinghouse covered by the federal privacy regulations or a business associate of these entities, the information described above may be redisclosed and no longer protected by the regulations.

_____ _____
Signature of the Patient/Guardian/Legal Representative Date Signed

_____ _____
Signature of Witness/Relationship to Patient Date Signed

Expiration Date: _____
One year from date signed