

**CNY DIAGNOSTIC IMAGING
MEDICAL RELEASE FORM**

The Health Insurance Portability and Accountability Act (HIPAA) now requires Health Care Providers to obtain consent to release certain medical information about you. Please fill out the following information. This information will be kept on file and you may make changes to this information at any time. I further understand that my rights are limited to any information in my "designated record set" as defined in Section 164.501 of the Code of Federal Regulations.

- May we call you if it is necessary to speak to you about an upcoming appointment or in reference to an examination that you have already had?

Yes No Phone Number: _____

May we leave a message? Yes No

- **Request & Fee:** I authorize CNY Diagnostic Imaging to obtain or release my Protected Health Information (PHI), to or from physicians and/or healthcare facilities necessary to treat and interpret my exam and complete quality assurance follow-up.

If I request a copy of my protected health information, I understand that CNY Diagnostic Imaging may charge me a reasonable fee for these records. Also, CNY Diagnostic Imaging may charge me for postage if I request my PHI be mailed to me.

CNY Diagnostic Imaging has 10 days to respond to this request. I understand I can cancel this authorization through written notice to CNY Diagnostic Imaging.

- **Form of Access & Summary:** I understand that CNY Diagnostic Imaging will provide me with access to PHI in a readable paper copy and/or x-ray film. Also, CNY Diagnostic Imaging will comply with my request for an alternate form or format only if they can readily produce the PHI in that form or format.
- Please list below any family member or others that have your permission to pick up your films or reports:

Name: _____

Name: _____

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have had the opportunity to review CNY Diagnostic Imaging's Notice of Privacy Practices and that a copy has been made available to me.

Patient Name-Printed

_____/_____/_____
Date of Birth

Patient Signature

_____/_____/200_____
Date

Signature of Parent or Guardian

_____/_____/200_____
Date

Witness

_____/_____/200_____
Date