



## CONSENT FOR TREATMENT

I understand that by signing this document I consent to have River Radiology provide diagnostic procedure(s) that my referring physician in his/her professional judgment deems medically necessary to diagnose a medical condition(s).

Signature of Patient/ Guardian: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Relationship of Guardian: \_\_\_\_\_

I consent to the use or disclosure of my Protected Health Information (PHI) by River Radiology for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills and to conduct the healthcare operations of River Radiology.

I understand that I have the right to request a restriction as to how my PHI is used or disclosed to carry out treatment, payment or the healthcare operations of River Radiology. River Radiology is not required to agree to the restrictions that I may request. However, if River Radiology agrees to a restriction that I request, the restriction is binding on River Radiology.

I have the right to revoke this consent, in writing, at any time, except to the extent that River Radiology has taken action in reliance on this consent.

River Radiology, in accordance with this Notice and without asking for consent or authorization, may use and disclose my Protected Health Information (PHI) for the purposes of:

**Treatment** – River Radiology may use and disclose my PHI to those health care professionals, whether on the Practice's staff or not, so that it may provide, coordinate, plan and manage my healthcare.

**Payment** – River Radiology may use and disclose my PHI so they may get paid for the services provided to me. River Radiology may provide my PHI, directly to a third party who may be responsible for my care, including insurance companies and health plans.

My Protected Health Information means health information, including my demographic information collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected information relates to my past, present or future physical or mental health or condition and identifies me, or there is a reasonable basis to believe the information may identify me.

*I understand I have a right to review River Radiology's Notice of Privacy Practices prior to signing this document. This notice has been offered to me in the reception area and is also posted on their website at [www.riverradiology.com](http://www.riverradiology.com) and describes the types of uses and disclosures of my PHI that will occur in my treatment, payment of my bills or in the performance of the health care operations of River Radiology. This Notice of Privacy also describes my rights and River Radiology's duties with respect to my protected health information. If I have any questions, I may contact River Radiology's HIPAA Compliance Officer.*

I understand that River Radiology reserves the right to change the privacy practices that are described in the Notice of Privacy Practices and that a copy of the revised notice will be made available to me.

Signed: \_\_\_\_\_ Date: \_\_\_\_\_  
Signature of Patient/Legal Guardian if patient is a minor

Name of Patient: (Please print) \_\_\_\_\_

Relationship of Guardian: \_\_\_\_\_