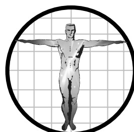


THE IMAGING CENTER
Radiology Centered On You

Standard Authorization of use and Disclosure of Protected Health Information

My signature below is acknowledgement that I have been notified of The Imaging Center's HIPAA Privacy Practices.

Information to be Used or Disclosed
The information covered by this authorization includes all reports, films and health information for the patient listed below.

Persons to Whom Information May Be Disclosed
Information described above may be disclosed to:
The Imaging Center, 499 Gloster Creek Village, Suite G1, Tupelo, MS 38801
Phone: 662-841-7880 • Fax 662-821-1888

Persons Authorized to Use or Disclose information
Information will be used or disclosed by:

____
Name or person or organization

Expiration Date of Authorization
This is effective through _____/_____/______ unless revoked or terminated by the patient or the patient's personal representative.

Right to Terminate or Revoke Authorization
You may revoke or terminate this authorization by submitting a written revocation to The Imaging Center. You should contact Tami Busby, Director of Human Resources/HIPAA Compliance Officer to terminate this authorization.

Potential for Re-disclosure
Information that is disclosed under this authorization may be disclosed again by the person or organization to which it is sent. 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*_____________________________________

OPTIONAL INFORMATION:

You may list up to three people that you would like to have access to your information at The Imaging Center.
(This should include people you may want to pick up films, reports, or confirm appointments on your behalf.)

1. ____

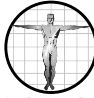
2. ____

3. ____

Please list any other physicians (other than the referring that you would like reports or films sent to:

1. ____

2. ____



THE IMAGING CENTER
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Patient Information

Name ____
Last First MI

Social Security #____________________________________

Date of Birth _______________________________________

Mailing Address _____________________________________

City/State/Zip ______________________________________

Home Phone ____

Work Phone ____

Sex (circle one) M or F

Height ______________ Weight __________________

Marital Status (circle one) Sgl M W D Sep

Race ____

Employment Status (circle one)
Full time Part time Retired Disabled Self Employed Not Employed Student

Employer ____

Date of injury ______________________________________

This is injury work related?___________________________

Responsible Party

Complete only if patient is Not financially responsible for self.

Relationship to Patient _______________________________

Name ____

Mailing Address _____________________________________

City/State/Zip ______________________________________

Home Phone ____

Work Phone ____

Date of Birth _______________________________________

Emergency Contact

Name ____

Phone ____

Relationship to Patient _______________________________

Insurance Information

Please present your Insurance cards(s) with this form

Primary Insurance:

Insurance Company ___________________________________

Insured's Relationship to Patient ________________________
*Please complete for Insured if **different** than patient/responsible party.*

Insured's Name _____________________________________

Date of Birth ____________________ Sex (circle one) M or F

Social Security #_______________________________________

Employer ____

Address ____

City/State/Zip _______________________________________

Home Phone ____

Work Phone ____

Secondary Insurance:

Insurance Company ___________________________________

Insured's Relationship to Patient ________________________
*Please complete for Insured if **different** than patient/responsible party.*

Insured's Name _____________________________________

Date of Birth ____________________ Sex (circle one) M or F

Social Security #_______________________________________

Employer ____

Address ____

City/State/Zip _______________________________________

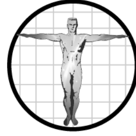
Home Phone ____

Work Phone ____

I hereby authorize the above listed insurance companies to pay directly to The Imaging Center benefits due me, if any, as provided in the above unexpired policy. I agree that I am ultimately responsible for charges incurred. I authorize The Imaging Center to release information to the insurance carrier(s) concerning my illness and/or treatment. I voluntarily consent to medical treatment.

____
Signature of Patient / Guardian

____
Relationship of Guardian to Patient



THE IMAGING CENTER

Radiology Centered On You

The Imaging Center is in network for the following insurance carriers:

- Advanced Health Systems
- American Life Care
- Beech Street
- Blue Cross Blue Shield
- Blue Cross Blue Shield Federal
- CCN USA
- Choice Care Network
- CorVel-CorCare
- First Health GEHA
- Creat West Healthcare
- Humana
- Medicaid of MS
- Medicare
- Medicare Rail Road
- Mississippi Physicians Health Care Network
- Multi Plan
- One Call Medical
- Private Health Care Systems
- ppoNEXT
- PPO USA
- Three Rivers Provider Network
- USA Managed Care Organization
- United Healthcare