BROADWAY IMAGING CENTER

Patient Information Form

Patient Name _____ Date of Birth _____

Address_____ Apt.#_____ City_____ Zip_____

Social Security #_____-_____-_____ Telephone (_____)_____-_____

Assignment of Benefits to Provider

I hereby authorize my insurance company to make payment(s) directly to Broadway Imaging Center for radiology services rendered to me on _____. I understand that I am financially responsible to the provider for any charges not covered by my benefit plan.

Protected Health Information-Privacy Notice

Please note that we maintain paper & electronic files that may contain private information about you that may include, but are not limited to your name, address, phone number, contact person, height & weight, diagnosis, prognosis, physician(s), prescriptions, plans of service & treatment, vital signs & other clinical impressions, insurance coverage(s), insurance coverage(s), equipment rented & purchased from us, credit card number(s), date of service, etc.

We release, transfer & disclose the above information to third parties to facilitate appropriate provisions & review of services & billing for our client's records. These files are legal documents & are used for education, evaluating the performance of our organization, marketing & planning purposes.

We have measures in place to protect patient health information as required by law. These measures include, but not limited to security precautions being in place in our building, vehicles, billing software, transactions with government entities, vendors, consultants, surveyors, your family or appointed representative & other appropriate parties, transmission of data to third-parties telephonic & wireless communications, maintenance, retention & destruction of data, etc.

You have the right to amend, restrict, revoke consent to release, examine or obtain copies of the data that we have in your file & have released to others upon request. If you have questions concerning any of the above, please contact our privacy officer at (818)548-0022. Effective 04/11/03.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I_____, hereby request and authorize the release of all my medical records including **Progress Notes, Hospital Records, Consultations. X-RAYS, EKG, Lab Reports, Immunization Records**, and information pertaining to the **Medical History, Mental and Physical condition**, services rendered, and treatments to:

BROADWAY IMAGING CENTER
140 North Glendale Ave.
Glendale, CA 91206
Tel: (818) 548-0022
Fax: (818) 548-8385

Signature of patient X_____ Date_____

If signed by a caregiver or other, please list the relationship & reason for signing. Example: Husband, Sister, etc. "patient unable to sign due to stroke."

Witnessed by staff X_____ Date_____