## PPI (Paesanos Parkway Imaging) Patient HIPAA Consent / Medical Release

**Consent for the use and disclosure of health information for treatment, payment or healthcare purposes.**

I have obtained, read and understand the Notice of Privacy Practices for Paesanos Parkway Imaging, which provides a complete description of information uses and disclosures.

I understand that:

- As a part of my healthcare, Paesanos Parkway Imaging originates and stores paper and/or electronic records pertaining to my health care and health history, including symptoms, examination and test results, diagnoses and treatment.
- I may revoke this consent, in writing, at any time with the exception of actions already taken. By refusal to sign or revoking of this consent form may result in dismissal of care or treatment as permitted by Section 164.506 in the Code of Federal Regulations.
- Paesanos Parkway Imaging reserves the right to change their Notice of Privacy Practices at any time as permitted by Section 164.520 in the Code of Federal Regulations. Should Paesanos Parkway Imaging change their *Notice of Privacy Practices,* they will send a copy of the revised notice to the address I've provided.
- It may be necessary for the organization to disclose my protected health information to another entity for treatment, healthcare or billing and payment purposes and I allow Paesanos Parkway Imaging to disclose this information to those entities.

I fully understand and accept the terms of this Patient HIPAA consent form. By signing below I acknowledge that I have received the *Notice of Privacy Practices* from Paesanos Parkway Imaging and have had any and all questions regarding these forms answered by the undersigned employee.

**PRIVACY NOTICE:** By signing below I acknowledge I have been given the opportunity to read and receive a copy of the PPI Notice of Privacy Practices that explains to me how PPI will use and disclose my information. I understand that PPI does not need my permission to disclose health information for purposes related to treatment, payment, or routine business operations.

**RELEASE OF MEDICAL RECORDS:** By signing this form below I hereby authorize release of my medical records, inclusive of all test results and pertinent information acquired during my treatment, to/from other physicians and healthcare providers. In addition, I understand that I have the right to request a copy of my medical record, or a portion thereof, at any time, and that PPI will do its best to respond to my request at the time of the request or as reasonably soon thereafter. I acknowledge and understand that I may incur fees associated with the copying of such medical records.

In addition, by sighing below, I hereby authorize the release and disclosure of my medical information to the following individuals:

| (Name) | (Relationship) | (Name) | (Relationship) |
|---|---|---|---|
| | | | |

This authorization extends to all of my protected health information that is disclosed for general information purposes and is valid until revoked. The information that may be disclosed includes but is not limited to: statements of charges or payments, records of visits for any and all dates, copies of records or reports provided to other physicians or providers, history and physical examination reports, and consultation reports. I understand that I may revoke this authorization at any time, except where information has already been released. The revocation must be in writing and sent to Attention: Privacy Officer, 3603 Paesanos Parkway #110, San Antonio, TX 78231. PPI, its employees, officers, and physicians are hereby release from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I further understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

**SIGNATURE (PATIENT / PARENT / LEGAL GUARDIAN)** **DATE**

**PRINTED NAME**