

PATIENT HEALTH INFORMATION REQUEST FORM

At which of the following number(s) do we have permission to contact you?

- Home _____ Work _____
 Cell Phone _____ Other _____

May we leave a message for you: at work? Yes No at home? Yes No cell? Yes No

Other than you or your insurance, whom may we talk to about your healthcare information?

NAME	PHONE NUMBER	RELATIONSHIP

In order to verify accurate health information before your imaging procedure, we will be going over the forms you completed in the waiting area and may need to ask you some additional questions, prior to entering the procedure room. While we will make every effort to respect your privacy, it is possible that you may be seen or overheard by other patients/family members. Will this be a problem for you?

Yes No

Do you have any health information that you would like kept confidential from any person or persons?

Yes No If so, please describe:

_____ I acknowledge that I have been given the opportunity to request restrictions on use and/or disclosure of my protected health information. I acknowledge that I have been given the opportunity to request alternative means of communication of my protected health information.

Would you like to designate a support person/patient representative? Yes No

If yes, list name of designated individual: _____

_____ I understand that by designating this individual as my support person/patient representative, I am hereby giving permission to share my protected health information with the designated individual.

- Your support person/patient representative may remain with you throughout your hospital stay, with the following exceptions:
 - During a treatment or procedure
 - In a medical emergency, at the physician's discretion

 Patient/Patient Representative Signature

 Date Time