Expert Breast Imaging

Patient Consent for Use and Disclosure of Protected Health Information (HIPPA)

I hereby give my consent for Expert Breast Imaging, LLC. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations. (TPO)

Expert Breast Imaging, LLC. Notice of Privacy Practices provides a more complete description of such uses and disclosures.

I acknowledge receipt of Expert Breast Imaging, LLC. P.C. Notice of Privacy Practices.

With this consent, Expert Breast Imaging, LLC. may call my home or other alternative location and leave a message on voicemail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including but not limited to laboratory results.

With this consent, Expert Breast Imaging, LLC. may mail and or send faxes to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminder cards and patient statements.

With this consent, Expert Breast Imaging, LLC. may e-mail to my home or other alternative location any items that assist the practice in carrying out TPO, such as appointment reminders and patient statements. I have the right to request that Expert Breast Imaging, LLC. restricts how it uses or discloses my PHI to carry out TPO.

However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to Expert Breast Imaging, LLC. use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, Expert Breast Imaging, LLC. may decline to provide treatment to me.

** Expert Breast Imaging, LLC. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by requesting a copy from the practice.

This Consent was signed by:

Signature of Patient or Legal Guardian _____

Name of Patient (Please Print) _____

Date Signed_____

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