UP&OPEN IMAGING
UPRIGHT MRI

PATIENT CONSENT FORM

I give this practice / clinic my consent to use or disclose my protected health information to carry out my treatment, to obtain payment from insurance companies, and for healthcare operations like quality reviews.

I have been informed that I may review the practice / clinic's Notice of Privacy Practices (for a more complete description of uses and disclosures) before signing this consent.

I understand that this practice / clinic has the right to change their privacy practices and that I may obtain any revised notices at the practice / clinic.

I understand that I have the right to request a restriction of how my protected health information is used. However, I also understand that the practice / clinic is not required to agree to the request. If the practice /clinic agrees to my requested restriction, they must follow the restriction(s).

I also understand that I may revoke this consent at any time, by making a request in writing, except for information already used or disclosed.

_____ _____

Signature of Patient or Legal Guardian Date

_____

If signed by patient representative, please state relationship to patient