

LONG ISLAND RADIOLOGY ASSOCIATES, P.C. for all d/b/a locations

OUR PRACTICE LOCATIONS

- | | | | |
|---|--|--|--|
| <input type="checkbox"/> Long Island Radiology
227 Franklin Avenue
Hewlett, NY | <input type="checkbox"/> Elmont OPEN MRI
545 Elmont Road
Elmont, NY | <input type="checkbox"/> Empire Imaging
113-02 Queens Blvd.
Forest Hills, NY | <input type="checkbox"/> Plainview MRI
6A Manetto Hill Plaza
Plainview, NY |
| <input type="checkbox"/> Central Diagnostic Imaging
37-08 28 th Avenue
Astoria, NY | <input type="checkbox"/> Midtown Radiology
316 East 30 th Street
New York, NY | | |

STANDARD AUTHORIZATION OF USE AND DISCLOSURE OF PATIENT HEALTH INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized the receive the information below is not a health plan or health care provider, then the released information may no longer be protected by federal privacy regulations.

Patient Name: _____ **ID Number:** _____

Organization Providing Information: Long Island Radiology Associates, P.C.

Organizations Receiving Information: Medical Data Base

Your protected health information may be used and disclosed by your physician, referring physician, our office and others outside of our office that are involved in your care and treatment for the purpose of providing health care services to you, to pay your health care bills. Any other identifiable health information may be disclosed as required by law.

USE OF PURPOSE OF DISCLOSURE:

The purpose of the use of disclosure: Report typing and Billing for Health Care Services

The description of information: All patient identifiable health information, for billing purposes such as, but not limited to: authorizations, letter of necessity, all information that needs transcribing, as well as any documents useful to ensuring the accuracy of those transcriptions. All relevant information required to file health care claim.

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

By my signature below I acknowledge that I have received a paper copy of Long Island Radiology Associates, P.C. notice of privacy practices.

We may use or disclose your protected health information in the following situations without your authorization or opportunity to object.

Public Health: for public health purposes to a public health authority or to a person who is a risk of contracting or spreading your disease.

Health Oversight: to a health oversight agency for activities authorized by law, such as audits, investigations, and inspections.

Abuse or neglect: to an appropriate authority to report child abuse or neglect, if we believe that you have been a victim of abuse, neglect or domestic violence.

Food and Drug Administration: As required by the Food and Drug Administration to track products.

Legal Proceedings: In the course of legal proceedings.

Law Enforcement: for law enforcement purposes, such as pertaining to victims of a crime or to prevent a crime.

Coroners, Funeral Directors and Organ Donors: for the coroner, medical examiner, or funeral director to perform duties authorized by law and for organ donation purposes.

Research: to researchers when their research has been approved by an Institutional Review Board or Privacy Board.

Soldier's, Inmates, and National Security: to military supervisors of Armed Forces personnel or to custodians of inmates, as necessary. Preserving national security may also necessitate disclosure of protected health information.

Worker's Compensation: to comply with worker's compensation laws or

No-Fault Laws: for disclosure to billing companies—all relevant information required to health care claims.

In general, we may use or disclose your protected health information as required by the law and limited to the relevant requirements of the law.

I hereby authorize the use or disclosure of my individually identifiable health information as described above. I understand that this authorization is voluntary.

Print Name

Patient Signature

Date

Patient Representative

Date