Upstate Carolina Radiology
Authorization of Use and Disclosure of Protected Health Information
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It is our policy to not release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone and/or pager. Whenever returning phone calls and the answering machine picks up, we will leave a message of the practice name, telephone number, and contact on the answer machine at your residence. Information will not be left with an unauthorized person. If you would like to have information released to someone other than yourself, please complete the following:

Appointment Reminders: The practice may use your information to remind you about upcoming appointments. Our practice will notify you of an upcoming appointment by telephone.

I _____, hereby authorize Southern Vascular Institute and staff to leave appointment reminders and medical information pertaining to my care by the following telephone numbers and I will assume responsibility to notify the practice whenever this information changes.

Home Telephone _____

Work Telephone _____

Cell Phone _____

If you have an answering machine, may we leave messages regarding appointments, treatments and/or other information pertinent to your healthcare and/or payment for your healthcare provided at Southern Vascular Institute?
Yes _____ No _____ (Southern Vascular Institute will leave a message only when the answer machine identifies the patient/household by name).

If "No" how else may we contact you regarding this information? _____

Please list any other restrictions regarding messages or reminders about your healthcare: _____

_____

Other Uses and Disclosures: Disclosure of your health information or its use for any purpose other than those listed in the "notice of Privacy Policies" brochure and/or consent will require your specific written authorization. If you change your mind after authorizing a use or disclosure of your information, you may submit a written revocation of the authorization. However, your decision to revoke the authorization will not affect or undo any use or disclosure of information that occurred before you notified us of your decision. You have the right to request restriction on use and disclosure of your health information.

I would like the following restrictions regarding the use and disclosure of my health information: _____

_____

_____

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Persons Authorized to Receive Information:

Print Name	**Contact Phone #**
_____ (Name of person / relation/ organization)	_____
_____ (Name of person / relation / organization)	_____
_____ (Name of person / relation / organization)	_____

Use and Disclosure of Information:

_____ I authorize the person(s) listed above to receive all health information about appointments, treatment and/or other Information pertinent to my healthcare and/or payment for my healthcare provided by Southern Vascular Institute.

_____ I do not authorize the following information to be disclosed to any other parties except to me as the patient (Please Specify).

_____

Expiration Date of Authorization: This authorization is effective through ____/____/____ unless revoked or terminated by the patient or patient's personal representative.

Right to Terminate or Revoke Authorization: You may revoke or terminate this authorization by submitting a written revocation to Southern Vascular Institute. You should contact the PRIVACY OFFICIAL or other authorized representative to terminate this authorization.

Potential for Re-disclosure: The person or organization to which health information is sent may repeatedly disclose health Information that is identified by this authorization. The privacy of this information may not be protected under the federal privacy regulations.

Acknowledgement: Please sign below, acknowledging you have been offered an opportunity to review our Notice of Privacy Practices:

_____
Name of Patient (Print or Type)

_____
Signature of Patient Date

_____
Signature of Patient Representative

_____
Relationship of Patient Representative to Patient

If you choose not to sign this acknowledgement form, please check the box, sign and date.

_____
Signature of Patient Date

Upstate Carolina Radiology
Financial Policy

I understand that I am financially responsible for all services rendered. If I am covered by an insurance company that requires a referral from my primary care physician, it is my responsibility to obtain that referral authorization prior to my visit. I will pay the charges I am responsible for today, whether it is a co-payment, deductible, co-insurance or payment in full by the following method ___ Patient Initials

PAYMENT AUTHORIZATION: I authorize insurance payment, if any, directly to Southern Vascular Institute. I realize I am responsible for non-covered services. ___ Patient Initials

INFORMATION RELEASE: I authorize Southern Vascular Institute to release to my insurance carriers or to the Social Security Administration and Health Care Financing Administration any information needed to determine benefits payable to related services. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. ___ Patient Initials

ACKNOWLEDGEMENT: I acknowledge all information above is accurate.

Signature of Patient or Legal Guardian, if a minor	Date