RADIOLOGY ASSOCIATES OF WAUSAU

OPEN MRI OF WAUSAU

AUTHORIZATION FOR SERVICES AND RELEASE OF PATIENT HEALTH INFORMATION

I, the signee, hereby consent to and authorize the attending physician, their assistants, and designees of Open MRI of Wausau – Weston Clinic (Open MRI) and Radiology Associates of Wausau, S.C. (Associates), to perform such examinations, procedures, treatments, and to administer such medications as in his or her opinion are necessary or advisable. This consent includes all, but is not limited to, diagnostic MRI's, CT's, Ultrasounds, and other Health Scan procedures.

I understand that Open MRI and Associates is not responsible for the loss of valuables such as wallets, purses, dentures, glasses, hearing aides, etc.

I hereby authorize payment of my medical benefits to Radiology Associates of Wausau, S.C. for services rendered to myself and/or any dependents. I understand that it is my responsibility to pay any deductible amount, co-insurance, or any other balance not paid for by my insurance.

I request that payment of approved Medicare benefits be made on my behalf to Associates for any services furnished by physician, clinic, or supervisor. I authorize any holder of my Protected Health Information to be released to the Centers for Medicare and Medicaid Services (CMS) and its agents, as well as any information needed to determine these benefits or the benefits payable for related services. I permit a copy of this authorization to be used in place of the original.

I understand that my Protected Health Information (PHI) is protected by law (as under current HIPAA regulations) and have been given a notice of privacy practices. I authorize Open MRI and Associates and its affiliates to release my PHI information, including medical and billing information, to my doctors, insurance companies, the responsible party named below and immediate family members on behalf of myself and/or dependents for the purposes of providing me with proper healthcare (treatment), to inform my family members of my condition, to inform appropriate agencies during disaster relief efforts, or where applicable by the Privacy Compliance Rule. Open MRI and Associates will not use PHI for the purposes of financial gain.

I also authorize my referring physician offices to release all prior films and other PHI as requested by Open MRI and Associates for the purposes of providing appropriate healthcare.

Other uses or disclosures of PHI not covered by this notice or the laws that apply to Open MRI or Associates will be make only with my written permission. I may revoke my permission at any time in the future, even if I do not do so at this time.

This authorization will automatically expire one year from the date of my signature below.

_____ Date: _____
(Signature of Patient)

_____ Date: _____
And when applicable signature of:
_____Parent or Legal Guardian _____Power of Attorney

NOTE: The Patient is required to sign this when authorization is required, unless the patient is a minor child, or is mentally and/or physically incompetent.