1069 Delaware Ave Ste 104 Marion, OH 43302 PH: 740-751-6828 Fax: 740-751-6829

Privacy Consent- For the Use and Disclosure of Protected Health Information

This consent is required by the Health Insurance Portability and Accountability Act of 1996 (HIPAA) to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Executive Imaging, LLC to use and disclose my protected health information for the purposes of treatment, payment and operations of my healthcare and this practice.

Consent for treatment: With my signature, I authorize Executive Imaging, LLC, its Affiliates and any employee working under the direction of the physician to provide treatment, for the purpose of evaluating my health and diagnosing medical condition.

Consent for payment and operations: I also authorize this practice to furnish my health information as needed to obtain payment for my health care services. This may include certain activities that my insurance plan may undertake before it approves or pays for health care services Executive Imaging, LLC recommends, such as: making determination of eligibility or coverage for insurance benefits, reviewing services provided to me for medical necessity, and undertaking utilization review activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. This release may include information about drug use/abuse, alcohol use/abuse, mental health issues or concerns, AIDS or HIV status as pertinent to my medical care. I Understand that these records are protected by the Code of Federal Regulations Title 43 Part 2 (42 CFR Part2) which prohibits the recipient of these records from making any further disclosers to the third parties without the express written consent of the patient.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy
Notice as part of this registration process. I understand the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice Privacy Officer by phone or writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement.

Patient Name Printed ____ DOB: ____________________

Guardian Name Printed (if Applicable): _________________________________

Patient/Guardian Signature: ____ Date:____________________

If not Patient, relationship: ____

Patient unable to sign due to: ____ Refusal to sign Date: _________