

OPTIMA DIAGNOSTIC IMAGING

CT • MRI • PET/CT • BONE SCAN

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I hereby authorize: _____

To release information from my medical records:

Patient Name: _____

Date of Birth: _____

Social Security Number: _____

Records Specifically Requested:

_____ X-Ray and/or PET or Nuclear Medicine Reports

_____ X-Rays and/or CT Scans

_____ X-Rays and/or MRI Scans

_____ X-Rays and/or Bone Scans

_____ Other: _____

Patient Signature Date

PLEASE FORWARD RECORDS TO:

Optima Diagnostic Imaging
8900 Wilshire Boulevard
Beverly Hills, CA 90211
Tel: 310-432-8999 Fax: 310-432-8995

Notice of Privacy Practices

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION AS REQUIRED BY THE PRIVACY REGULATIONS CREATED AS A RESULT OF THE HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996 (HIPAA). PLEASE REVIEW IT CAREFULLY.

Our pledge to you.

We understand that medical information about you is personal. We are committed to protecting medical information about you. Each time you visit a hospital, physician or other healthcare provider, a record of your visit is made. This notice applies to all of the records of your care that we maintain, whether created by facility staff or your personal physician.

As required by law, we will:

- keep medical information about you private;
- provide, or make available, as applicable, this notice of our legal duties and privacy practices with respect to medical information about you; and
- follow the terms of the notice that is currently in effect.

Obtain a copy of this notice

You have the right to a current copy of this notice. You may obtain a copy of this notice any time in person or by written request.

How we may use and disclose medical information about you

We will share medical information about you for purposes of treatment, such as sending medical information about you to your physician or specialist as part of a referral, to obtain payment for treatment, and to support health care operations. We may also share medical information about you for purposes of coordinating your care and treatment with other providers such as acupuncturist, psychologist, nutritionist, massage therapist, Chinese medicine practitioner, herbalist, tai chi instructor, energy healer, massage therapist or other integrative medicine therapist from whom you may consider seeking care from, or indeed seek care from, irrespective of whether such providers are employees of our office, independent contractors of our office, or wholly unaffiliated with our office.

We may use health information about you without prior authorization for several other reasons. Subject to applicable law to carry out their duties, we may give out medical information about you to other entities for:

- public health authorities that are authorized by law to collect the information (such as, births, deaths, public surveillance)
- abuse, neglect or domestic violence reporting when it is a threat to your safety and the safety of another individual or the public
- health oversight audits or inspections
- research studies
- workers' compensation purposes
- emergencies
- requests from law enforcement, or in response to valid judicial or administrative orders

Your rights regarding medical information about you

- You have the right to look at or get a copy of medical information that we use to make decision about your care. We will provide you with a form you can complete to make the request. If you request copies, however, we may charge a fee for copying, mailing and other related supplies. If we deny your request to review or obtain a copy, you may submit a written request for review of that decision.
- You have the right to request us to amend your health information if you believe it is incorrect or missing. We will provide you a form which you can complete to make the request. We may deny your request to amend a record if the information was not created by us, if it is not part of medical information maintained by us, or if we determine that the record is accurate. If we deny your request to amend, you may submit a request to review that decision by us not to amend the record.
- You have the right to make a written request to us for a list of instances where we have disclosed medical information about you other than for treatment, payment, health care operations or where you specifically authorized disclosure.
- You have the right to request that medical information about you be communicated to you in a confidential manner.
- You may request, in writing, that we not use or disclose medical information about you for treatment, payment or healthcare operations or to persons involved in your care except when specifically authorized by you, when required by law, or in an emergency. We will consider your request but our processes may not be able to accommodate it and we are not legally required to accept it. We will inform you of our decision on your request.

All written requests for review of denials should be submitted to our Facility Privacy Officer

Other uses of medical information

In any other situation not covered by this notice, we will ask for your written authorization before using or disclosing medical information about you. If we request and obtain your authorization to use or disclose your medical information, you can later revoke authorization by notifying us in writing.

Complaints

If you are concerned that your privacy rights may have been violated, or you disagree with a decision we made about access to your records, you may contact our Facility Privacy Office in writing. Finally, you may send a written complaint to the U.S. Department of Health and Human Services Office of Civil Rights. Under no circumstance will you be penalized or retaliated against for filing a complaint.

If you have any questions regarding this Notice of Privacy Practices please contact us at Optima Diagnostic Imaging, 8900 Wilshire Blvd, Beverly Hills, CA 90211, or call 310-432-8999.

Facility Privacy Officer

Patient HIPAA Statement

I understand as part of my healthcare, Optima Diagnostic Imaging originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

- A basis for planning my care and treatment;
- A means of communication among the many health professionals who contribute to my care;
- A source of information for applying my diagnosis and health information for billing purposes;
- A means by which a third-party payer can verify that services billed were actually provided;
- And a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I acknowledge that I have read and understand Optima Diagnostic Imaging's *Notice of Privacy Practices*, which provides a more complete description of information uses and disclosures. I have the right to review this notice prior to signing this consent. I understand the organization reserves the right to change their notice and practices at any time and I may request a copy of any revised notice by contacting our Privacy Officer at (310) 432-8999.

I understand I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations and that this organization is not required to agree to the restrictions requested.

This acknowledgement is given freely with the understanding that any and all records, whether written, oral or in electronic format, are confidential and cannot be disclosed without my prior written authorization, excepted as authorized by law. A photocopy or fax of this consent is as valid as this original.

Print Patient's Name	Date
----------------------	------

Patient's Signature (or personal representative)	Date
--	------

OPTIMA DIAGNOSTIC IMAGING

CT • MRI • PET/CT • BONE SCAN

PATIENT QUESTIONNAIRE

Name: _____ Date of Birth: _____ Today's Date: _____

1 Reason for today's visit? _____

2 Do you have any allergies? Yes No If yes, please include allergies to drugs, foods, environment, or latex and the type of reaction: _____

3 Medical History (please mark all that apply):

- | | | |
|--|--|--|
| <input type="checkbox"/> Asthma | <input type="checkbox"/> Gastrointestinal Problems | <input type="checkbox"/> Seizure Disorder |
| <input type="checkbox"/> Bleeding Disorder | <input type="checkbox"/> Heart Disease | <input type="checkbox"/> Shortness of Breath |
| <input type="checkbox"/> Blood Disease | <input type="checkbox"/> High Blood Pressure | <input type="checkbox"/> Skin Condition |
| <input type="checkbox"/> Bone Disorder | <input type="checkbox"/> Implanted Device | <input type="checkbox"/> Stroke |
| <input type="checkbox"/> Cancer | <input type="checkbox"/> Infectious Disease | <input type="checkbox"/> Thyroid Disorder |
| <input type="checkbox"/> Chipped / Loose Teeth | <input type="checkbox"/> Kidney Disease | <input type="checkbox"/> Family History of Anesthesia Problems |
| <input type="checkbox"/> Collagen V | <input type="checkbox"/> Liver Disease | <input type="checkbox"/> Family History of Kidney Disease |
| <input type="checkbox"/> Dentures | <input type="checkbox"/> Mental Illness | |
| <input type="checkbox"/> Diabetic | <input type="checkbox"/> Multiple Myeloma | |
| <input type="checkbox"/> Dialysis | <input type="checkbox"/> Neurologic: | |
| <input type="checkbox"/> Dizziness / Fainting | <input type="checkbox"/> Pulmonary (Lung) Disease | |

4 Previous Hospitalizations / Surgery (Date / List / Describe): _____

5 Medications:

Have you taken any blood thinners in the last 10 days? Yes No

Name	Dose	Frequency	Last Taken

6 Have you had any imaging studies recently? Yes (list) _____ No

7 Are you pregnant? Yes No N/A Last Menstrual Period _____

8 Do you have an Advanced Directive? Yes No

(An advance directive tells your doctor what kind of care you would like to have if you become unable to make medical decisions (if you are in a coma, for example).

If yes, please sign below acknowledging that USC Radiology Associates' policy does not recognize any Advanced Directives.

Signature

Date