RADIOLOGY ASSOCIATES of HARTFORD, P.C.

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Enfield • 9 Cranbrook Blvd
Glastonbury • 31 Sycamore Street

Phone: (860) 714-2724
Fax: (860) 714-8808

Consent and Acknowledgement

Thank you for choosing Radiology Associates of Hartford, P.C. for your health care. We will do our best not only to meet, but to exceed your expectations during your visit. Please read this form in its entirety, and then sign where indicated below.

I consent to the use or disclosure of my protected health information by Radiology Associates of Hartford to any person or organization for the purposes of carrying out treatment, obtaining payment or conducting certain health care operations. Protected health information used or disclosed by Radiology Associates of Hartford may include HIV/AIDS related information, psychiatric and other mental health information, and drug and alcohol treatment information, as long as such information is used or disclosed in accordance with Connecticut and Federal law, which may require you to provide specific authorization. I understand that information regarding how Radiology Associates of Hartford will use and disclose my information can be found in Radiology Associates of Hartford's Notice of Privacy Practices. I understand that this consent is effective for as long as Radiology Associates of Hartford maintains my protected health information.

By signing below, I understand and acknowledge the following:

- I have read and understand this consent and acknowledgement; and
- I have read Radiology Associates of Hartford's Notice of Privacy Practices currently in effect.

Print Name of Patient or Responsible Party _____

Signature of Patient or Responsible Party_____ Date _____

If signed by the patient's representative, describe the legal authority of the representative to act on behalf of the patient

_____

Unable to obtain consent and acknowledgement because:

- ☐ Patient refused to sign
- ☐ Emergency treatment situation
- ☐ Patient not able to sign due to incompetence or other medical reason
- ☐ Other _____

ASSIGNMENT OF PHYSICIAN'S BENEFITS

I hereby authorize payment directly to RADIOLOGY ASSOCIATES OF HARTFORD, P.C. of the professional fees associated with radiological procedures and/or surgical benefits, if any, otherwise payable to me for its services. I hereby authorize the above physicians to release any information acquired in the course of my examination or treatment necessary for billing purposes.

I understand that I am financially responsible for the charges not covered by this authorization.

Date:_____ Signed:_____

Radiology Associates of Hartford Notice of Privacy Practice (HIPPA)
I am a patient, (or parent or legal guardian of the patient), of Radiology Associates of Hartford, P.C. I hereby acknowledge receipt of Radiology Associates of Hartford's Notice of Privacy Practices.

Name (please print): _____

Relationship to Patient: ☐ Patient ☐ Parent ☐ Legal Guardian

Signature:_____ Date:_____

Please visit our website for additional information regarding any procedure ***www.rahxray.com***