1030 North Charles Street, Baltimore, Maryland 21201
10840 Little Patuxent Parkway, Suite 202, Columbia, MD 21044
Phone: 410.605.9393 Fax: 410.605.9397
www.dedicatedimaging.com

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Dedicated Imaging of Baltimore is dedicated to preserving the privacy of your protected health information. We are requesting this Patient Acknowledgement and Authorization to give you notice of our privacy practices and how we may use and disclose protected health information about you.

We are requesting that you acknowledge receipt of the following Privacy Practices by your signature below.

1. We may ask you to sign your name on a list of patients and will call your name out loud in our public waiting Area.
2. We may call your home and work to remind you of upcoming appointments, inform you of test results, or ask You to return our call; in the event you are not there, we may leave a message on an answering machine or With the individual who answers the phone.
3. We may receive and send your protected health information, including test results, pathology and radiology Reports and prescriptions, electronically, by fax and by telephone, to other health care providers, laboratories, Pharmacies and Medicare/Insurance carriers.

We reserve the right to change the terms of our above described Privacy Practices by notice to you at your next visit to this office. You have the right to request restrictions on how your protected health information may be used to disclose for treatment, payment, or health care operations. We are not required to agree to your restrictions, but if we do, we are bound by our agreements with you provided it is in writing and signed by both of us.

If you are concerned that we may have violated your privacy rights or you disagree with a decision we made about your individual rights, you may use the contact information listed at the end of this notice to file a complaint with us. You may also submit a written complaint to DHHS. We will provide you with the contact information to DHHS upon request.

We support your right to protect the privacy of your protected health and financial information. We will not retaliate in any way if you choose to file a complaint with us or with DHHS.

BY SIGNING THIS FORM, YOU CONSENT TO OUR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION ABOUT YOU FOR TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. You have the right to revoke this consent in writing, except where we have already made disclosures in trust on your prior consent.

I, the undersigned Patient, request that payment of the authorized Medicare/Insurance carrier benefits be made on my behalf to Dedicated Imaging of Baltimore for any services furnished to me. I authorize any holder of medical information about me to release to the Centers for Medicare/Medicaid Services and its agent and/or any other insurance carriers for which I have coverage, any information needed to determine these benefits or the benefits payable for related services. I agree to provide all referral and treatment plans as required by my insurance carriers. All co-pays must be paid at the time of service in accordance with the contract Insurance Carrier agreements.

Contact:
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Baltimore, MD 21201
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Ask for HIPAA Compliance and Privacy Office

______________________________________ Signature of Patient

____________________ Date