

RapidSound, Inc / Green Valley Imaging  
450 W Continental Rd  
Green Valley, AZ 85622  
520.625.7670

## PATIENT CONSENT FORM

The Department of Health and Human Services has established a 'Privacy Policy' to help ensure that personal information is protected for privacy. The 'Privacy Rule' was also created in order to provide a standard for certain health care providers to obtain their patients' consent for uses and disclosures of health information about the patient to carry out treatment, payment, health care options and collections.

As a patient of **RapidSound, Inc**, we want you to know that we respect the privacy of your personal medical information and do all we can to secure and protect that privacy. We strive to always take reasonable precautions to protect your privacy. When it is appropriate and necessary, we provide the minimum necessary information to only those we feel are in need of your health care information and information about treatment, payment or health care operations, in order to provide health care that is in your best interest.

**RapidSound, Inc** also wants you to know that we support your full access to your personal medical records. We may have indirect treatment relationships with you (such as laboratories that only interact with physicians and not patients), and may have to disclose personal health information for purposes of treatment, payment, or health care operations. These entities are most often not required to obtain patient consent.

You may refuse to consent to the use or disclosure of your personal health information, but this must be in writing. Under this law, we reserve the right to refuse treatment should you refuse to disclose your Personal Health Information (PHI). If you choose to give consent in this document, at some future time you may request to refuse all or part of your PHI. You may not revoke actions that have already been taken which relied on this or a previously signed consent.

You have the right to review our privacy notice, to request restrictions and to revoke consent in writing after you have reviewed our privacy notice.

### AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION, PAYMENT OF ACCOUNT

I authorize **RapidSound, Inc** to release medical information for insurance purposes concerning treatment of the patient. I authorize payment of any insurance benefits for medical or surgical services directly to **RapidSound, Inc**. I agree to pay fees not covered by insurance benefits directly to **RapidSound, Inc**. If collection proceedings are required, I agree to pay all reasonable collection fees.

Print Name: \_\_\_\_\_

*Nombre*

Signature: \_\_\_\_\_

*Firma*

Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Fecha*

DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

*Fecha de Nacimiento*

I have been advised that a copy of my patient rights, as outlined in the *AZDHS rules Article 10, section R9-10-1008*, has been made available to me by **RapidSound, Inc / Green Valley Imaging**.

Accepted

Waived