RADIOLOGY CONSENT FORM

CS 9300 CBCT HIGH RESOLUTION REDUCED EXPOSURE
2410 SAMARITAN DR. STE 102 SAN JOSE (408) 819-3199

I, _____

Patient/Patient Guardian

give my consent to undergo an X-ray Computed Tomography (CAT Scan or CT Scan) of the paranasal sinuses, or temporal bones, or dental anatomy. The risks, alternatives and benefits of this procedure have been explained to me and I understand and accept them and wish to proceed.

_____ _____

Patient/Patient Guardian Date

Authorization for Release of Information

I hereby authorize the use or disclosure of my identifiable health information as described below. I understand that this authorization is voluntary and that I may revoke it at any time by submitting a revocation in writing to the entity providing the information.

Participant Name:_____ ID Number_____

Person(s) authorized to provide information:_____

Person(s) authorized to receive information:_____ Info to be disclosed_____

VIP Diagnostic Imaging will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above. This authorization will expire _____
(Indicate date or an event relating to you personally or to the purpose of the authorization).

IMPORTANT INFORMATION ABOUT YOUR RIGHTS

I have read and understood the following statements about my rights:

- I may revoke this authorization at any time prior to its expiration date by notifying VIP Diagnostic Imaging in writing, but the revocation will not have any effect on any actions the entity took before it received revocation.
- I may see and copy the information described on this form if I ask for it.
- I am not required to sign this form to receive my benefits.
- The information that is used or disclosed pursuant to this authorization may be re-disclosed by VIP Diagnostic Imaging. I have the right to seek assurances from the above – named person(s) authorized to receive the information that they will not re-disclose the information to any other party without my further authorization.

_____ _____

Signature of Participant Date

_____

Printed Name of Participant's Personal Representative Relationship to the Participant