Patient Authorization to Release Healthcare Information

We will retrieve your records and images from your prior imaging center for you. Please complete this form and send to Austin Breast Imaging by scanning and emailing or via fax.

Fax: 512.339.6360
Email: patientaccess@austinbreastimaging.com

Patient's Name: _____ DOB: _____

Previous name (if applicable): _____

I request and authorize _____ *(prior imaging center)* to release my protected healthcare information to:

Austin Breast Imaging
12319 N. MoPac Expressway
Building C, Suite 320
Austin, Texas 78758
Phone: 512.776.1000

This request and authorization applies to the following: (check all that apply)

☐ Mammogram Images and Reports Dates of Service _____
☐ Ultrasound and Images and Reports
☐ Pathology Reports
☐ Bone Density Reports
☐ MRI Images and Reports
☐ Other: _____

The protected health information is being used or disclosed for the following purpose:

☐ Per patient's request for comparison ☐ Other: _____

_____ *Initials* I understand that, as set forth in the provider's policy notice, I have the right to revoke this authorization at any time by sending written notification to the above address or fax number.

_____ *Initials* For screening mammograms, if your comparison mammograms do not arrive in 7 business days then your mammogram will be read at that time without comparison.

Patient Signature _____ Date Signed: _____

History for Bone Density Scan

austin BREAST IMAGING

In Partnership with rose imaging SPECIALISTS

Date: _____

Name: _____ Gender: _____ DOB: _____

Height: _____ Weight: _____ Referring Doctor: _____

Ethnicity: ☐ Black ☐ White ☐ Hispanic ☐ Asian ☐ Other: _____

Build: ☐ Small ☐ Average ☐ Large

Current Medications: _____ _____ _____

_____ _____ _____

_____ _____ _____

Is there any chance you may be pregnant?	☐ Yes	☐ No
Are you right handed or left handed?	☐ Right	☐ Left
Have you gone through menopause?	☐ Yes	☐ No
If yes, how old were you?	_____	
Have you had a hysterectomy?	☐ Yes	☐ No
If yes, how old were you?	_____	
Have you had hip replacement surgery?	☐ Yes	☐ No
If yes, which hip was replaced?	☐ Right	☐ Left
Have you had any surgery on your back?	☐ Yes	☐ No
If yes, what procedure?	_____	
Do you have a known curvature (scoliosis) of your spine?	☐ Yes	☐ No
Have you had a CT scan, barium enema, bone scan or any other contrast study within the past 7 days?	☐ Yes	☐ No
If yes, which exam?	_____	
Do you have a family history of osteoporosis?	☐ Yes	☐ No
Do you take estrogen replacement, calcium supplements or other osteoporosis medication treatment?	☐ Yes	☐ No
If yes, how long have you been taking this medication?	_____	

Is this patient a suspected victim of abuse? ☐ Yes ☐ No Patient tolerated exam ☐ Yes ☐ No

Is this patient a fall risk? ☐ Yes ☐ No Patient discharged without complaint ☐ Yes ☐ No

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Technologist Name: _____ Date: _____

Technologist Signature: _____ Time: _____

Patient Insurance and Consent

Exam Date: _____

Name: _____ Date of Birth: _____Age: ____

Address: _____

Home Phone: _____

Work Phone: _____Cell Phone: _____

Referring Physician: _____

Primary Insured Name: _____Primary Insured DOB: _____Relationship to Insured: _____

Primary Insurance Company: _____ Insurance Phone#: _____

ID#: _____ Group#: _____

Secondary Insurance: _____

1.) I understand that it is my responsibility to contact my physician for my results. 2.) I authorize ABI to mail information to me and to identify themselves when leaving a phone message. 3.) I understand that I am responsible for payment of all charges resulting from this visit. 4.) The Radiologist and Pathologist bill separately from ABI. 5.) I have been informed that some insurance carriers will only pay for one screening mammogram every 365 days. 6.) I am aware that any diagnostic studies may be subject to my deductible and/or not covered by my insurance policy. This includes screening mammograms that turn into diagnostic mammograms. 7.) If I elect to have my insurance filed ABI, I give irrevocable authorization that this be done with signature on file. A photo static copy will serve as the original. 8.) I authorize ABI to release or request copies of medical records and x-rays pertinent to the course of my examination. 9.) I certify that I have read and received this information prior to my diagnostic Imaging exam and that I understand its contents.

I hereby assign any and all right, title, and any interest in any benefits whatsoever of any insurance policy or policies whatsoever to AB for charges of services and expenses rendered and provided by them. I further agree to, and will pay for all charges and expenses not provided for or covered by my insurance. I further authorize ABI Comprehensive Breast Center to release any and all information acquired by them in the course of my treatment.

Patient Signature _____Date _____

_____ I understand that I have received a copy of the Health Insurance Portability and Accountability Act (HIPAA) from this facility concerning how the use and disclosure of Protected Health Information is handled by the practice.

Mammography Disclosure and Consent

You have the right as a patient to be informed about any diagnostic procedure that might involve even though minimal, any risks or complications. This disclosure is not meant to frighten or alarm you, it is simply an effort to make you better informed. X-ray examination of the breast (mammography) is the most accurate method of detecting breast cancer. You should understand, however, that a mammogram is not 100% effective in detecting all breast cancers. Some cancers may be seen on the x-ray study but cannot be felt on physical examination. Other cancers can be felt on physical examination, but cannot be seen on x-ray study. It is estimated that 10% of cancers cannot be detected by the mammogram in certain types of breasts. A negative or normal mammogram does not completely exclude the possibility of breast cancer. Additional views of your breast may be requested by the radiologist. We will call you if this is necessary. It does not mean that your mammogram is abnormal. If you have not had a recent breast examination by a health professional prior to the mammogram, you must contact your doctor for a breast examination. Please remember to perform your monthly Self Breast Examination and notify your doctor of any changes, thickening or lumps that you might encounter. Compression of the breast is necessary to obtain the best possible views of the inside of your breast with the least amount of radiation. This kind of compression, while briefly uncomfortable, is better for you in the long run. It helps us take much clearer x-rays of your breast with much less radiation. It is important for you to realize that compression isn't dangerous and it doesn't damage breast tissue in any way. It also doesn't cause long term discomfort. The presence of an implant poses a special situation for mammographic technique and interpretation since a portion of the breast tissue may be obscured by the implant. In addition, implants are subject to complications such as the possibility of rupture, leakage, or displacement during compression. Even though these complications are not common, you as a patient need to know that they can occur.

Please initial the correct statement: _____ I do NOT have breast implants _____I do have breast implants

Radiation can potentially be harmful to a developing fetus. If there is any possibility that you are pregnant, this exam must be discussed with your physician and possibly rescheduled.

Please initial the correct statement: _____ I could possibly be pregnant _____ I am NOT pregnant

Patient Signature _____Date _____

HIPAA Privacy Policy

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.

This Privacy Notice is being provided to you as a requirement of a federal law, the Health Insurance Portability and Accountability Act (HIPAA). This Privacy Notice describes how we may use and disclose your protected health information to carry out treatment, payment, or health care operations and for other purposes that are permitted or required by law. It also describes your right to access and control your protected health information. Your "protected health information" means any written or oral information about you, including demographic data that can be used to identify you, created or received by your health care provider, which relates to your past, present, or future physical or mental health or condition.

Uses and Disclosures of Protected Health Information for Treatment, Payment, and Health Care Operations

We may use your protected health information for the purposes of providing treatment, obtaining payment for treatment, and conduction health care operations. Your protected health information may be used or disclosed only for these purposes unless we have obtained your authorization or the use or disclosure is permitted or required by the HIPAA regulations or other law. Disclosures of your protected health information for the purposes described in this Privacy Notice may be made in writing, orally, or by electronic means.

1. Treatment. We will use and disclose your protected healthcare information to provide, coordinate, or manage your health care and related services, including coordination and management with third parties for treatment purposes. Here are some examples of how we may use or disclose your protected health information for treatment:
   a. We may disclose your protected health information to a laboratory to order tests.
   b. We may disclose your protected health information to other physicians who may be treating you or consulting with us regarding your care.
   c. We may disclose your protected health information to those who may be involved in your care after you leave here, such as family members or your personal representative.

2. Payment. We will use your protected health information to obtain payment for the services we provide to you. We may also disclose your protected health information to another provider involved in your care for their payment activities. Here are some examples of how we may use or disclose your protected health information for payment:
   a. We may communicate with your health insurance company to get approval for the services we render, to verify your health insurance coverage, to verify that particular services are covered under your insurance plan, and to demonstrate medical necessity.
   b. We may disclose your protected health information to anesthesia care providers involved in your care so they can obtain payment for their services.

3. Health Care Operations. We may use and disclose your protected health information to facilitate our own health care operations and to provide quality care to all of our patients. Health care operations include such activities as: quality assessment and improvement; employee review activities; conduction or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance reviews; business planning and development; and business management and general administrative activities. In certain situations, we may also disclose your protected health information to another provider or health plan for their health care operations. Here are some examples of how we may use or disclose your protected health information for health care operations:
   a. We may use your protected health information to review our treatment and services and to evaluate the performance of our staff in caring for you.
   b. We may combine protected health information about many patients to decide what additional services we should offer, what services are not needed, and whether certain new treatments are effective.
   c. We may also disclose information to doctors, nurses, technicians, medical students, and other personnel for review and learning purposes.
   d. We may also use or disclose your protected health information in the course of maintenance and management of our electronic health information systems.

Other Uses and Disclosures. As part of the functions above, we may use or disclose your protected health information to provide you with appointment reminders, to inform you of treatment alternatives, or to provide you with information about other health-related benefits and services which may be of interest to you.

Uses and Disclosures of Protected Health Information Permitted without Authorization or Opportunity for the Individual to Object

The federal privacy rules allow us to use or disclose your protected health information without your authorization and without your having the opportunity to object to such use or disclosure in certain circumstances, including:

1. When Required By Law. We will disclose your protected health information when we are required to do so by federal, state, or local law.
2. For Public Health Reasons. We may disclose your protected health information as permitted or required by law for the following public health reasons:
   a. For the prevention, control, or reporting of disease, injury or disability;
   b. For the reporting of vital events such as birth or death;
   c. For public health surveillance, investigations, or interventions;
   d. For purposes related to the quality, safety, or effectiveness of FDA-regulated products or activities, including:
      • Collection and reporting of adverse events, product defects or problems, or biological product deviations.
      • Tracking of FDA-regulated products.
      • Product recalls, repairs, or lookback.
      • Post-marketing surveillance.
   e. To notify a person who has been exposed to a communicable disease or who may be at risk of contracting or spreading a disease or condition;
   f. Under certain limited circumstances, to report to an employer information about an individual who is a member of the employer's workforce.
3. To Report Abuse, Neglect, or Domestic Violence. We may notify government authorities if we believe a patient is a victim of abuse, neglect, or domestic violence. We will make this disclosure only when specifically authorized or required by law, or when the patient agrees to the disclosure.
4. For Health Oversight Activities. We may disclose your protected health information to a health oversight agency for oversight activities authorized by law, including audits; civil, administrative, or criminal investigations; inspections; licensure or disciplinary actions; civil, administrative, or criminal proceedings or actions; or other activities necessary for appropriate oversight.
5. For Judicial or Administrative Proceedings. We may disclose your protected health information in the course of any judicial or administrative proceeding in response to an order of a court or administrative tribunal as expressly authorized by such order. We may disclose yourprotected health information in response to a subpoena, discovery request, orother lawful process that is not accompanied by an order of a court or administrative tribunal if we have received satisfactory assurances that you have been notified of the request or that an effort has been made to secure a protective order.
6. For Law Enforcement Purposes. We may disclose your protected health information to a law enforcement official for law enforcement purposes, including:
   a. Wound or physical injury reporting, as required by law.
   b. In compliance with, and as limited by the relevant requirements of a court order or court-ordered warrant, a subpoena, summons, or similar process.
   c. Identification or location of a suspect, fugitive, material witness, or missing person. Under certain limited circumstances when you are the victim of a crime.
   d. Alerting law enforcement of the death of an individual where there is suspicion that the death may have resulted from criminal conduct.
   e. Reporting criminal conduct that occurred on the premises of the provider. In an emergency to report a crime.
7. To Coroners, Medical Examiners, and Funeral Directors. We may disclosed protected health information to a coroner or medical examiner for the purpose of identifying a deceased person, determining a cause of death, or other duties as authorized by law. We may disclose protected health information to funeral directors, consistent with applicable law, as necessary to carry out their duties with respect to the decedent. In some cases such disclosures may occur prior to, and in reasonable anticipation of, the individual's death.
8. For Organ or Tissue Donation. We may use or disclose protected health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of cadaveric organs, eyes, or tissue for the purpose of facilitating dona-

tion and transplant.
9. For Research Purposes. We may use or disclose your protected health information for research purposes when an institutional review board that has reviewed the research proposal and protocols to safeguard the privacy of your protected health information has approved such use or disclosure.
10. To Avert a Serious Threat to Health or Safety. We may, consistent with applicable law and standards of ethical conduct, use or disclose your protected health information if we believe, in good faith, that such use or disclosure is necessary to prevent or lessen a serious and imminent threat to your health and safety or that of the public.
11. For Specialized Government Functions. We may use or disclose your protected health information, as authorized or required by law, to facilitate specified government functions related to military and veterans activities; national security and intelligence activities; protective services for the President and others; medical suitability determinations; correctional institutions and other law enforcement custodial situations.
12. For Workers' Compensation. We may use and disclose your protected heath information, as necessary, to comply with workers' compensation laws or similar programs.

Uses and Disclosures of Protected Health Information Permitted without Authorization but with an Opportunity for the Individual to Object

We may use your protected health information to maintain a directory of patients in our facility. The information included in the directory will be limited to your name, your location in our facility, and your condition described in general terms.

We may disclose your protected health information to a friend or family member who is involved in your medical care or payment for care. In addition, if applicable, we may disclose medical information about you to an entity assisting in a disaster relief effort so that your family can be notified about your condition, status and location.

You may object to these disclosures. If you do not object to these disclosures, or we determine in the exercise of our professional judgment that it is in your best interest for us to disclose information that is directly relevant to the person's involvement with your care, we may disclose your protected health information.

Uses and Disclosures of Protected Health Information which You Authorize

Other than the uses and disclosures described above, we will not use or disclose your protected health information without your written authorization. Authorizations are for specific uses of your protected health information, and once you give us authorization, any disclosures we make will be limited to those consistent with the terms of the authorization. You may revoke your authorization, by submitting a revocation in writing, at any time, except to the extent that we have already taken action in reliance upon your authorization.

Your Rights Regarding Your Protected Health Information

You have the following rights regarding your protected health information:

1.The Right to Request Restriction of Uses and Disclosures. You have the right to request that we not use or disclose certain parts of your protected health information for the purposes of treatment, payment, or healthcare operations. You also have the right to request that we do not disclose your protected health information to friends or family members who may be involved in your care, or for notification purposes as described earlier in this notice. Your request must be made in writing and must state the specific restriction requested and the individuals to whom the restriction applies.

We are not required to agree to a restriction you may request. We will notify you if we do not agree to your restriction request. If we do agree to the restriction request, we will not use or disclose your protected health information in violation of the agreed upon restriction, unless necessary for the provision of emergency treatment.

We may terminate our agreement to a restriction if you agree to the termination in writing; if you agree to the termination orally and the oral agreement is documented, or if we notify you of termination of the agreement and the termination applies only to protected health information created or received by us after you receive the notice of termination of the restriction.

Request for restrictions must be made in writing to the Privacy Officer.
2. The Right to Request Confidential Communications. You have the right to request that you receive communications of protected health information from us by alternative means or at alternative locations. We must accommodate any reasonable request of this nature. We may condition the provision or accommodation by requesting information from you describing how payment will be handled, or by requesting specification of an alternative address or alternative form of contact.

Requests for confidential communications must be made in writing to the Privacy Officer.

The Right to Inspect and Copy Protected Health Information. You have the right to inspect and obtain a copy of your protected health information that is maintained in a designated record set for as long as we maintain the protected health information. The designated record set is a collection of records maintained by us, which contains medical and billing information used in the course of your care, and any other information used to make decisions about you.

By law, you do not have a right to access psychotherapy notes; information compiled in reasonable anticipation of, or for use in, a civil, criminal, or administrative proceeding; and protected health information which is subject to a law which prohibits access to protected health information. Depending on the circumstance of your request, you may have the right to have a decision to deny access reviewed.

We may deny your request to inspect or copy your protected health information if, in our professional judgment, we determine that the access requested is likely to endanger you or another person, or is likely to cause substantial harm to another person referenced within the protected health information. You have a right to request a review of a denial of access.

If you request a copy of your information, we may charge you a fee for the costs of copying, mailing, or other costs incurred by us as a result of complying with your request.

Requests for access to your protected health information must be made in writing to the Privacy Officer.
4. The Right to Amend Protected Health Information. You have the right to request that we amend your protected health information in a designated record set for as long as we maintain that information. In certain cases we may deny your request. If we deny your request you will be notified in writing, and you will have the right to file a statement of disagreement with us. We may prepare a rebuttal to your statement of disagreement and if we do so we will provide a copy of our rebuttal to you.

Requests for amendment of protected health information must made in writing to the Privacy Officer, and must include a reason to support the requested amendments.
5. The Right to Receive an Accounting of Disclosures of Protected Health Information. You have the right to request an accounting of disclosures of your protected health information made by us. This right applies to disclosures made by us except for disclosures: to carry out treatment, payment, or health care operations as described in this Notice or incidental to such use; to you or your personal representatives; pursuant to your authorization; for our directory, or other notification purposes, or to persons involved in your care; or for certain other disclosures we are permitted to make without your authorization.

Requests for disclosure of accounting must specify a time period sought for the accounting, with the maximum time period being six years prior to the date of the request. We are not required to provide accounting for disclosures made before April 14, 2003. We will provide the first disclosure accounting you request during any 12-month period without charge. Subsequent disclosure accounting request will be subject to a reasonable cost-based fee.
6. The Right to Obtain a Paper Copy of this Notice. Upon request, we will provide a paper copy of this notice.

Your Rights Regarding Your Protected Health Information

We are required by law to maintain the privacy of your health information and to provide you with this Privacy Notice of our legal duties and privacy practices with respect to protected health information. We are required to abide by the terms of the Notice currently in effect. We reserve the right to change the terms of this Notice and to make any new provisions effective for all protected health information that we maintain. If we change the Notice, we will provide a copy of the revised notice through in-person contact.

Your Rights Regarding Your Protected Health Information

You have the right to express complaints to us and to the Secretary of the Department of Health and Human Services if you believe that your privacy rights have been violated.

If you wish to complain to us, please do so in writing, and direct your complaint to the Privacy Officer. You will not be penalized for filing a complaint.

Contact Information

For further information about this Notice, please contact:
Monica Erickson, Austin Breast Imaging
12319 N. MoPac Expressway
Building C, Suite 320
Austin, Texas 78758
512.776.1000