SOUTHWEST DIAGNOSTIC CENTER OF COLORADO SPRINGS
X-RAY QUESTIONNAIRE and CONSENT

NAME: _____ DATE OF BIRTH: _____

REFERRING PHYSICIAN: _____

Describe Symptoms: _____

_____

Date of Injury: _____

Any recent films related to this injury? _____ Date of previous exam: _____

If yes, where was the exam done? _____

GENERAL CONSENT

I hereby consent to the performance of the x-ray of _____.

I understand that there may be potential risks to my unborn child. I authorize Southwest Diagnostic Center of Colorado Springs to do whatever may be necessary in the event any unforeseen condition arise during the course of the procedure. I understand that no guarantee has been made as to the results that may be obtained.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, _____, acknowledge that I have received a copy of Southwest Diagnostic Centers' Notice of Privacy Practices. This notice describes how Southwest Diagnostic Center may use and disclose my protected health information, certain restrictions on the use and disclosure of my healthcare information, and rights I may have regarding my protected health information.

MEDICAL RECORDS AUTHORIZATION TO DISCLOSE

I authorize the release of any medical information in regard to the services which are provided to me by Southwest Diagnostic Centers to any physician or health care provider by whom I have been or will be treated who request such information.

I authorize the disclosure of my medical records/information to the persons listed below. I understand this is a voluntary request to release my health information to someone other than healthcare providers. I understand only the individuals identified below are authorized to received copies, pick up my medical records or inquire about my account at Southwest Diagnostic Centers (this includes my spouse, parents, family members, friends, children, etc). I also understand identification confirmation for any requesting individual will be confirmed and documented prior to the release of my record information.

1. _____ 2. _____ 3. _____

Can Southwest Diagnostic Centers leave information related to your account, appointment and/or any other medical record information on your answering machine or voicemail?

YES NO (please circle)

_____ _____

Signature **Relationship if other than patient**

_____ _____

Witness Signature **Date**