Steinberg Diagnostic
Medical Imaging Centers
"Where Imaging Revolves Around You"℠

2950 South Maryland Parkway, Las Vegas, Nevada 89109
4 Sunset Way, Building D, Henderson, Nevada 89014
2767 N. Tenaya Way, Las Vegas, Nevada 89128
2850 Siena Heights, Henderson , Nevada 89052
9070 W. Post Road, Las Vegas, Nevada 89148

(702) 732-6000

Patient Consent to the Use and Disclosure of Health Information

I understand that as part of my health care, ***Steinberg Diagnostic Medical Imaging (SDMI)*** originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnoses, treatment, and future care or treatment. I understand that this information serves as a basis for planning my care and treatment, a means of communication to those who contribute to my care, a source of information for applying diagnosis, and a means by which a third-party payer can verify that services billed were actually provided.

I understand that I do have the right to restriction to the use or disclosure of my health information but ***SDMI*** is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing, except to the extent that the organization has already take action in reliance thereon. I also understand that by refusing to sign this consent or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I understand that ***SDMI*** may leave a message on my answering machine and or with a third party regarding limited protected health information, pending appointments, and the time and place of my scheduled appointments, or other healthcare related communications.

I give the following persons access to the use or disclosure of my health information:

_____

_____

I understand that as part of this organization's treatment, payment, or health care operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosure for these permitted uses, including disclosures via fax.

I have been presented with a copy of ***SDMI's*** **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law.

Signed:_____ **Date:**_____

Print Name:_____

If not signed by patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witnesses by:** _____

Acknowledgement Refused

Presented on (date and time):_____

Patient Name: _____

Reason for Refusal: _____

Signature of Provider Employee:_____

Internal Use Only:
Patient Name: _____ ID No: _____