Muir Oncology Imaging and Treatment Center
3000 Oak Road, Suite 111, Walnut Creek, California 94597
Phone 925-937-2248 Fax 925-937-2389

Authorization for Use of Disclosure of Protected Health Information

Patient Name: _____ Date of Birth: ___/___/____ Phone: _____

I authorize any MD or medical facility pertaining to my continuation of care to release my Medical Imaging Records for the purpose of to:

Muir Oncology Imaging & Treatment Center

**Information to be released in form of: ☒CD (Computer Disc) ☒Written Report

INFORMATION TO BE DISCLOSED: Please indicate the type(s) of exams and the date(s).

☒PET/CT ☒Diagnostic CT

Exam: _____ Date of Exam: _____

Exam: _____ Date of Exam: _____

Exam: _____ Date of Exam: _____

Exam: _____ Date of Exam: _____

Exam: _____ Date of Exam: _____

This authorization shall become effective immediately. This consent is subject to revocation by the undersigned at any time between now and the release of information by the sending person, agency or institution. I understand that I may revoke this authorization by writing a letter to MOITC and that my revocation will not affect actions taken by this medical practice prior to the receipt of this letter of revocation.

Authorization for Use of Disclosure of Protected Health Information, I understand that this information may not be further disclosed unless another authorization is obtained from me or unless such use of disclosure is specifically required or permitted by law. I understand that I do not have to sign this authorization in order to get healthcare benefits (treatment, payment, or enrollment).

I understand that although federal law does not protect health information which is disclosed to someone other than another health care provider, health plan or health care clearinghouse, under California law all recipients of health care information are prohibited from re-disclosing it except as specifically required or permitted by law.

_____ ___/___/____ _____
Patient Signature Date Parent/Guardian

POWER OF ATTORNEY documentation must be provided by custodian if applicable. (Copy and attach)

_____ ___/___/____ _____
Designee's Signature Date Driver's License Number

_____ ___/___/____
Witness Signature Date

MUIR ONCOLOGY
Imaging and Treatment Center

CONSENT FOR CT SCAN WITH IODINATED CONTRAST

In order to evaluate your medical condition, your physician has requested a computerized tomography (CT) examination. A CT examination has some contraindications. When the contrast material is an iodine-based compound, an examination should not be performed if there is a history of an allergic reaction to iodinated contrast material. Your physician and the radiologist must be notified if an allergy exists. In rare instances, hypersensitivity has occurred in patients with no known allergies. The use of iodine-based contrast material is also contraindicated in some medical conditions. Prior to your study today, the radiologist and/or technologist will review your medical profile with you to screen for the presence of risk factors that might increase the likelihood of adverse reactions.

Yes	No	
		Have you ever had a reaction to a previous scan (ex: hives, sneezing, cough)
		Do you have a known allergy to X-ray contrast?
		Do you have other allergies (medications, seasonal)?
		List:
		Do you have diabetes?
		Do you have kidney disease?
		Is there any chance you may be pregnant?

CONSENT: A CT exam, its indications and contraindications, and the risks versus benefits of radiation exposure have been fully explained to me. Having complete knowledge of this procedure, I give my consent and permission to have the CT exam performed.

By signing below, I understand that all medical procedures may involve discomforts as well as risks. I have had sufficient opportunity to discuss the proposed procedure and risks with my physician and all of my questions have been answered to my satisfaction. I also certify by signing this consent that, to the best of my knowledge, I am not pregnant.

_____ _____

Patient Signature Date

_____ _____

Witness Signature Date

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From time to time it may become necessary to contact you by telephone. Often our patients are not available when we call them and we would like to be able to leave telephone messages when possible. In order to protect your privacy, we need your written permission to leave telephone messages with family members or on your voice message system.

Please read the following choices and tell us whether or not we can leave a voice message regarding your appointments, and with whom we may leave it with.
NOTE: We will never call you regarding your results or medical care… please contact your referring provider for such information.

Choose ONE of the following (yes or no):

☐ **YES, I DO CONSENT to leave messages as follows:**

I, _____ give Muir Oncology Imaging & Treatment Center & their staff my permission to leave telephone messages regarding my appointments with the following options:

(Initial each one that you want us to be able to use for leaving you telephone messages). This will remain in effect until you rescind it in writing.

My home phone (number)_____ Initials_____

My cell phone (number) _____ Initials_____

My spouse (name): _____ (number): _____ Initials _____

My Email: _____ Initials _____

Other (name): _____ Phone number_____ Initials _____

Other (name): _____ Phone number_____ Initials _____

If YES, Sign Here: _____ **Date:** _____

OR

☐ **NO, I <u>DO NOT</u> CONSENT to leave ANY messages:**

I, _____ wish to be contacted personally at the number listed below and I **DO NOT AUTHORIZE** ANY messages regarding my appointments be left on any answering machine, voice mail or with others.

Call only this number:_____ Initials _____

If NO, Sign Here: _____ **Date:** _____

Revocation of prior consent: (sign here only if you wish to stop above authorizations)

I, _____, wish to rescind or stop the *above* authorizations.

Signature_____ **Date:**_____