AUTHORIZATION AND ASSIGNMENT

I HEREBY AUTHORIZE Capitol Radiology Associates LLC, Laurel Radiology Services and the physicians of Medical Imaging Network, to apply for benefits on my behalf for covered services rendered to me. I requested payment from Blue Cross/Blue Shield of the National Capital Area. Medicare Part B or other insurance carriers be made directly to the provider of services. I certify that the information I have reported in regard to my insurance is correct. I authorize the release of medical or other necessary information for this or any Health Care Financing Administration. I permit a copy of this authorization to be used in place of the original. I authorize the release of my radiographs and/or reports as requested orally or in writing by my physician(s) or me. I consent for the procedure to be performed on myself or (minor). I have read and consent to the authorization and assignment stated above.

X_____ _____/_____/_____

Signature of Patient or Personnel Representative Date

PRIVACY NOTICE

Acknowledgement – RECEIPT OF NOTICE OF PRIVACY PRACTICES

By the signature below, I acknowledge receipt of the providers Notice of Privacy Practices

X_____ _____/_____/_____

Signature of Patient or Personnel Representative Date

The following individuals may be allowed to discuss my medical/billing records:

_____ _____

Name(s) Relationship

FOR INTERNAL USE ONLY

I presented the patient or personal representative with the Notice of Privacy Practices, but the patient or personal representative refused to sign the acknowledgement.

_____ _____/_____/_____

Signature of Imaging Center Personnel Date