PATIENT CONSENT TO TREAT

DATE: **NAME:**

I authorize Wilson Imaging Centers to perform diagnostic X-Rays as prescribed by Dr..

Lead aprons will be used for all X-Ray exposures.
We are unable to use a thyroid collar for Panoramic and Lateral Skull images as the apron will interfere and block the patients anatomy of interest.

Any questions about the necessity of the X-Rays prescribed will need to be directed to your referring doctor.

We do not diagnose or treat patients and cannot offer an opinion about your treatment. I understand that the records will be sent to my referring doctor. Records will not be released to the patient or any other doctor without the written release from the referring doctor. There is a fee for duplicate records.

NOTICE OF PATIENT PRIVACY

I understand that I have certain rights regarding my protected health information. These rights are given to me under the Health Insurane Portability and Accountabliity Act of 1996(HIPAA). I understand that by signing this consent I authorize you to use and disclose my protected health information to carry out:

***Treatment including direct or indirect treatment by other healthcare providers involved in my treatment.**

I have also been informed of and given the right to review and secure a copy of Notice of Privacy Practices, which contains a more complete description of the uses and disclosures of my protected health information and my rights under HIPAA. I understand that I may contact you at any time to obtain the most current copy of this notice.

I understand that I may revoke this consent, in writing, at any time. However, any use or disclosure that occurred prior to the date I revoke this consent is not affected.

Patient Signature: _____Date_____

MINOR PATIENTS

I am the parent or guardian of TRACING who is a minor.
I authorize Wilson Imaging Centers to perform diagnostic X-Rays as prescribed by Dr..

Parent / Guardian_____Date_____

Print Name_____