NETWORKradiology
P: 216.291.8480 - F: 216.291.8490

CONSENT TO USE AND DISCLOSE HEALTH INFORMATION
AND
ACKNOWLEDGEMENT AND RECEIPT OF NOTICE

This acknowledgement of Notice and Consent authorizes ***Network Radiology*** to use and disclose health information about you for treatment, payment and health care operations purposes.

Notice of Privacy Practices. The above named practice has a Notice of Privacy Practices. It describes how we may disclose and use your protected health information (PHI) and how you can access and exercise other rights concerning your PHI.

Right to Make Amendments. We reserve the right to change our Notice of Privacy Practices and to make the terms of any change effective for all protected health information that we maintain, including information created or obtained prior to the date of the effective date of change.

You may obtain a revised notice by submitting a written request to our Privacy Officer at the address listed below:

NETWORK RADIOLOGY
BRAINARD PLACE MEDICAL CENTER
29001 CEDAR ROAD, SUITE 100
LYNDHURST, OHIO 44124

YOU SHOULD REVIEW OUR CURRENT NOTICE PRIOR TO SIGNING THIS ACKNOWLEDGEMENT AND CONSENT.

I have received the Notice of Privacy Practices for ***Network Radiology***. This practice is authorized to use and disclose health information about _____
Print Patient Name
for treatment, payment and healthcare operation purposes consistent with its Notice of Privacy Practices.

It is the policy of ***Network Radiology*** not to honor patient's advanced directives. In the event of an emergency, our physician will treat the patient and if deemed necessary, 911 will be called.

I have read the above and grant my consent to have the imaging procedure performed.

X_____ _____
Signature of Patient or Representative — Date

_____
Relationship to Patient if not self