



7135 Perkins Road – Baton Rouge, LA 70808 ♦ 225.765.8600

Authorization for Imaging Services

I hereby consent to treatment by the attending physician and other medical staff for all medical procedures as deemed necessary by myself and the medical staff.

Authorization for Release of Information and Assignment of Benefits

I hereby assign to the above named office, those benefits otherwise payment under title XVIII (Medicare) is correct and complete. I authorize the holder of medical related information about me to be released to the Health Care Finance Administration or other health care coverage entity, any information for this or any related health care claim in writing or verbally. I further understand and agree to pay for services or amounts due when appropriate. These charges could include amounts applied to my annual deductible co-payment amounts, and charges denied as not covered by my insurance program or deemed medically unnecessary. I understand that well care is not covered by Medicare or many other health insurance programs.

I hereby authorize release of my films and/or medical records as needed for subsequent medical care. In the event of positive findings, I authorize my attending physician to release the results of my biopsy/surgery to my referring physician named above for their records.

If someone other than the patient is signing this authorization, please state the relationship with patient and the reason patient is unable to sign.

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT OF 1996
PRIVACY OF HEALTH INFORMATION

I acknowledge the receipt of (HIPAA Form # 12.0 4/14/03 Revised 05/09/05), Lake Imaging Center's Privacy Policies. If I should have any further questions, I understand that I may contact the HIPAA Compliance Officer of Lake Imaging Center:

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Signature: _____ Date: _____