RADIOLOGY Regional
Powered by LucidHealth

Protected Health Information (PHI) Disclosure Authorization

Patient Email Address: _____

By providing your email address, you agree to receive email notices from RRC, including notifications regarding your patient portal account or PowerShare, our Image Sharing product.
If you register for the portal or PowerShare with a shared email account, please be advised that all users of that email account may gain access to the medical information contained within the portal or PoweShare and may be able to access and/or reset the password for the portal or PowerShare. If you wish to protect your medical information from such access, do not register for the portal or PowerShare with a shared email account or share your email password with anyone.
****Emailed records sent to an unencrypted email address may be viewable by an unauthorized party. By selecting this delivery method, you understand and accept the inherent risks of receiving records via email to the address you specify.***

Emergency Contact Name: _____ **Phone:** _____

RRC may release any information to the family and friend(s) you list below. (copies of exams, test results, appointment times & dates, medical & financial information)

Name:	**Relationship:**
_____	_____
_____	_____
_____	_____

Create a security password _____ (To access your account if requesting information by phone)

I understand that I can revoke this authorization at any time by written request to RRC and that it is otherwise valid for one year. I understand that RRC may not condition treatment, payment, enrollment, or eligibility of benefits on whether I sign this authorization. I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer subject to applicable privacy laws.

Patient Signature: _____ **Date:** _____

Print Name: _____ **Birth Date:** _____

Guardian/Representative Signature: _____ Date: _____

Relationship to patient: _____

*** Please Complete Form on the Back ***

Acknowledgment of Receipt of Notice of Privacy Practice

By signing this form, you acknowledge that you have received or have been informed that you have the right to receive a copy of Radiology Regional Notice of Privacy Practice.

This notice is available in hard copy by verbally requesting a copy at the front desk of any Radiology Regional facility or by submitting a request in writing to the HIPAA Privacy Officer at Radiology Regional, 3660 Broadway, Ft. Myers, FL 33901.

You may also view and/or print a copy of the Notice of Privacy Practice by visiting Radiology Regional website at www.radiologyregional.com, select the For Patients tab and click on the Privacy Policy option.

Patient Signature: _____ **Date:** _____

Print Name: _____ **Birth Date:** _____

Guardian/Representative Signature: _____ Date: _____

Relationship to patient: _____

NOP FORM
Rev 2/6/24