

HAWAII RADIOLOGIC ASSOCIATES, LTD.

IMAGING CENTER

KONA OFFICE: 77-311 Sunset Drive Kailua-Kona, Hawaii 96740 Phone: (808) 329-7314 Fax (808) 329-5510

(Patient's) Last Name		First Name		Middle Initial	Date of Birth	Age	Sex <input type="checkbox"/> M <input type="checkbox"/> F	Date of Exam
(Guarantors) Last Name		First Name		Middle Initial	Known Allergies			Appt Time
Address				Date of Injury / Pregnancy (LMP)		Injury type: <input type="checkbox"/> Work <input type="checkbox"/> Auto <input type="checkbox"/> Other		
City		State		Zip		Description of injury:		
Home		Telephone		Work		Report Type <input type="checkbox"/> Routine Report <input type="checkbox"/> Stat Report <input type="checkbox"/> Phone Report <input type="checkbox"/> Fax Report Fax Number: _____		
Primary Insurance		Note: If you are on "AUTOFAX" services you will automatically be sent your reports via fax. Please check one:						
Secondary Insurance		<input type="checkbox"/> Patient to Wait <input type="checkbox"/> Patient return w/film		<input type="checkbox"/> Patient may leave <input type="checkbox"/> Patient return w/ film and report				
Clinical Information				Exam(s) not listed below				
Referring Physician Signature X				Date		Cc:		

HEAD			UPPER EXTREMITIES			ULTRASOUND			
SINUSES COMPLETE			CLAVICLE			R	L	NECK (THYROID)	
FACIAL BONES COMPLETE			SCAPULA			R	L	ABDOMEN COMPLETE	
ORBITS			SHOULDER			R	L	RENAL	
NASAL BONES			AC JOINTS					AORTA	
MANDIBLE COMPLETE			HUMERUS			R	L	OB COMPLETE	
SKULL COMPLETE			ELBOW COMPLETE			R	L	FETAL BIOPHYSICAL PROFILE	
TMJ BILATERAL			FOREARM			R	L	PELVIC ROUTINE	
CHEST/RIBS			WRIST COMPLETE			R	L	PELVIC (TRANSABDOMINAL ONLY)	
CHEST 2 VIEWS			HAND COMPLETE			R	L	HYSTEROSONOGRAPHY	
CHEST 1 VIEW			FINGERS			R	L	SOFT TISSUE MASS (SUBCUTANEOUS)	
CHEST SPECIAL VIEWS			LOWER EXTREMITIES			CAROTID ULTRASOUND BILATERAL			
RIBS UNI 2 VIEWS			R	L	HIP UNI COMPLETE			NONINVASIVE EXTREMITY VENOUS (DVT) R L	
RIBS UNI + PA CXR			R	L	PELVIS / HIPS INFANT			SCROTUM	
STERNUM			FEMUR			R	L	BLADDER WITH POST-VOID RESIDUAL	
STERNOCLAVICULAR JOINT			KNEE AP BILAT STAND 1 VW					PEDIATRIC HIP (CHD)	
GASTROINTESTINAL			KNEE 2 VIEWS			R	L	DEXA BONE DENSITOMETRY	
ESOPHAGUS			KNEE 3 VIEWS (ROUTINE)			R	L	<input type="checkbox"/> Post-Menopausal <input type="checkbox"/> Pre-Menopausal DX:	
UGI AIR CONTRAST (AC)			KNEE 4 VIEWS			R	L		
UGI AC W/ SBFT			LOWER LEG (TIB-FIB)			R	L		
ORAL CHOLECYSTOGRAM (GB)			ANKLE 3 VIEWS			R	L		
T-TUBE CHOLANGIOGRAM			FOOT 3 VIEWS			R	L		
SBFT (SMALL BOWEL STUDY)			CALCANEUS			R	L		
BE AIR CONTRAST			TOES			R	L	VASCULAR SCREENING	
SPINE			ABDOMEN			VASCULAR SCREENING SEGMENTAL PRESSURE			
CERVICAL SPINE LIMITED 2 VIEWS			KUB						
CERVICAL COMPLETE			ABDOMEN 2 VIEWS						
CERVICAL SPINE COMP W FLEX/EXT			ACUTE ABD SERIES (INCL PA CHEST)						
THORACIC SPINE COMPLETE			GENITOURINARY						
LUMBAR SPINE COMPLETE			IVP W/ TOMOGRAM						
LUMBAR SPINE COMPLETE W/BEND VW			VOIDING CYSTO						
PELVIS			MISCELLANEOUS						
SACRUM/COCCYX			BONE AGE						
SCOLIOSIS PA & LAT			BONE LENGTH						
SCOLIOSIS PA									
SI JOINT BILATERAL									

SPECIAL INSTRUCTIONS AND PREP:

TECHNOLOGIST NOTES:

**CONSENT TO USE AND DISCLOSE
PROTECTED HEALTH INFORMATION**

I hereby give my consent to HAWAII RADIOLOGIC ASSOCIATES, LTD. ("HRA"), to release and disclose my medical information, reports, and records compiled, produced, or created by HRA with respect to radiology and other services performed by HRA (collectively, the "Medical Records"): (a) to any health plan or health insurer, including, but not limited to, third party payors, workers' compensation and no-fault insurance carriers, that provide any health care coverage or similar insurance coverage to me, for any purpose related to payment of HRA's charges; (b) to any insurance company that provides professional liability insurance to HRA to evaluate clinical performance; (c) pursuant to any subpoena or other legal process or as otherwise required by law; (d) to any provider that is federally mandated under the Mammography Quality Standards Act of 1992, as amended; and (e) to the provider or entity who referred me to HRA for radiology services for my continued treatment.

- ❖ I understand that by this consent protected health information may be used and disclosed to carry out treatment, payment or health care operations.
 - ❖ I acknowledge that I have been provided with a *Notice of Privacy Practices* (the "Notice") by HRA which provides a more complete description of how protected health information may be used or disclosed by HRA. I understand that I have the right to review the Notice prior to signing this consent. I also understand that HRA may change its privacy practices described in the Notice and will mail a copy of any revised notice to me prior to implementation at the address I have provided.
 - ❖ I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or health care operations. I also understand that HRA is not required to agree to the requested restrictions, but if HRA does agree to the requested restrictions, it will be bound by them.
 - ❖ I understand that I may revoke this authorization at any time by providing written notification to HRA, and that such revocation will not affect any actions taken by HRA before it received my written notification.
- I request the following restrictions to the use or disclosure of my health information.

Name of Patient

Patient's Social Security Number

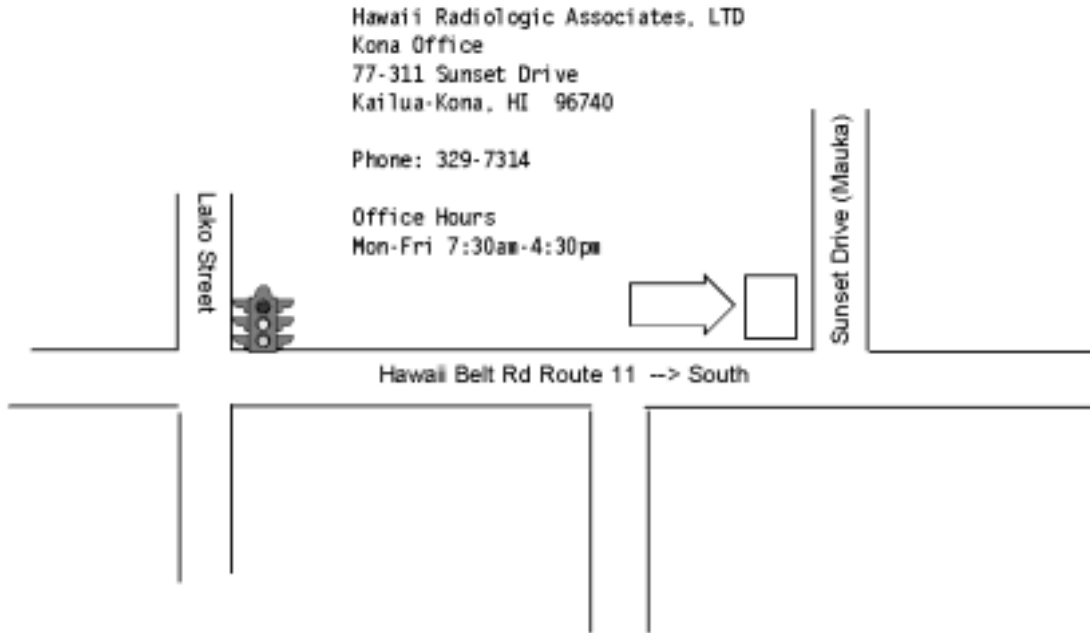
Signature of Patient or Patient's Representative

Date

Name of Patient's Representative:

Relationship to Patient:

Mailing Address of Patient or Patient's Representative:



SNF STAMP: