HIPPA PRIVACY DOCUMENT

Health Insurance Portability & Privacy Act of 1996

(Must be completed by every patient/guardian to see the doctor)

I, the patient/guardian, by signing this understand I am giving Galaxy MRI & Diagnostic Center the authorization to treat me. They are only allowed to disclose my health information with my insurance company, pharmacy, and the referring physician by law. You may specify below whom if anyone you would like us to release your health information to. If you would like a brochure explaining the HIPPA laws in depth we do have those available. You may also request a copy of this form.

*Please state below any physician, family member, or person who you would allow to have access to your medical records.

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Print Name

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Signature Date