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 ☐ M ☐ F	Date of Exam
(Guarantors) Last Name	First Name	Middle Initial	Known Allergies			Appt Time
Address			Date of Injury / Pregnancy (LMP)		Injury type: ☐ Work ☐ Auto ☐ Other	
City	State	Zip	Description of injury:			
Home	Telephone	Work	Report Type			
Primary Insurance			☐ Routine Report Note: If you are on "AUTOFAX" services you will automatically be sent your reports via fax.		Stat Report ☐ Phone Report ☐ Fax Report Fax Number: ____________________	
Secondary Insurance			Please check one: ☐ Patient to Wait ☐ Patient may leave ☐ Patient return w/film ☐ 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	☐ Post-Menopausal ☐ Pre-Menopausal		
UGI AIR CONTRAST (AC)			KNEE 4 VIEWS	R	L	DX:		
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.

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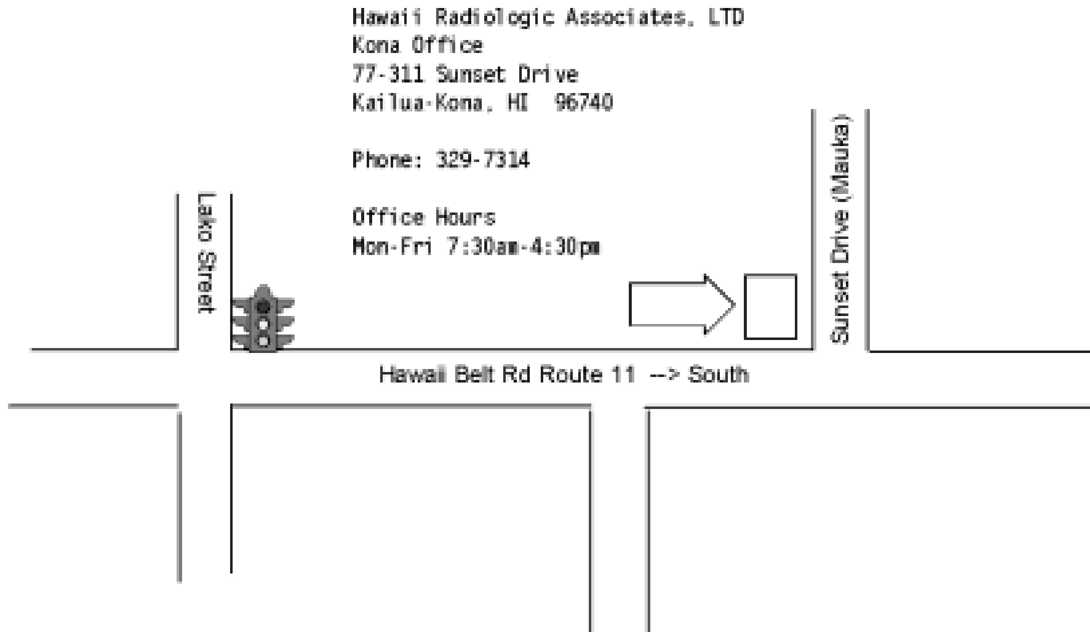
____   _________________________________
Name of Patient   *Patient’s Social Security Number*

____
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: