# Brain and Spine Imaging Center

A Division of Olympia Neurology, PLLC

**AUTHORIZATION AND CONSENT**

**Patient Name: _____Date of Birth: _____**

**RECEIPT OF PRIVACY NOTICE**
I acknowledge receipt of the Olympia Neurology (dba Brain & Spine MRI Center) Notice of Privacy Practices.

**AUTHORIZATION AND ASSIGNMENT: MEDICARE/MEDIGAP/OTHER INSURANCE**
I authorize any holder of medical or other information about me to release to Social Security Administration, Health Care Financing Administration, its intermediaries, other carrier or commercial insurance company, any information needed for the processing of my medical claims. I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits to the party who accepts assignment. Regulations pertaining to Medicare assignment of benefits apply. I understand it is mandatory to notify the health care provider of any other party who may be responsible for paying for my treatment (Section 1128B of the Social Security Act and 31 U.S.C. 3801-3812 provides penalties for withholding this information.)

I have read, understand, and herby consent to the MRI examination and the above conditions.

Signature: _____ Date: _____

**CONTRAST INJECTION**
MRI Contrast medium is sometimes administered to patients during the exam to enhance the visibility of certain tissues in the body. All patients are screened for prior history to reduce any reaction to contrast medium, which is very rare. If you are breast-feeding, have had prior allergic reaction or creatinine levels in question please discuss this prior to injection with the technologist. All patients are screened for prior history to reduce any reaction to contrast medium, which is very rate. I hereby authorize Olympia Neurology, PLLC dba to administer an IV (intravenous) MRI contrast medium if necessary during the MRI examination Olympia Neurology, PLLC dba is hereby authorized to be furnished with any and all medical information (including but not limited to Hospital records, reports, x-rays, and opinions), pertaining to the patient. I authorize the release of any necessary medical information to Olympia Neurology, PLLC dba to assist in my diagnosis.

I have read, understand, and herby consent to the MRI examination and the above conditions.

Signature of Patient: _____ Date: _____

Signature of Parent/ Guardian (if not 18):_____ Date:_____