MODIFIED BARIUM SWALLOW STUDY

AUTHORIZATION TO EVALUATE / RELEASE OF INFORMATION

Patient Name: _____ HIC: _____

Ordering physician: _____

TO: PATHEOUS HEALTH I hereby authorize PATHEOUS HEALTH to evaluate me under the plan of treatment as authorized by my physician(s). This evaluation may include any one or all of the following procedures as indicated: Videofluoroscopic view of the larynx, a modified barium swallowing function study including lateral and A-P views with an esophageal scan.

TO: _____ (Facility name), I hereby authorize you to release any medical records in your possession concerning my illness and/or treatment to PATHEOUS HEALTH as requested.

TO: _____ (Patient's Primary Physician's Name), I hereby authorize you to release any medical records in your possession concerning my illness and/or treatment to PATHEOUS HEALTH as requested.

TO: Social Security Administration: I hereby authorize you to verify the correctness of my Medicare Number and/or birth date as requested by PATHEOUS HEALTH.

TO: PATHEOUS HEALTH I hereby authorize the above agency to release any medical records in its possession concerning my illness and/or evaluations to physicians, hospitals, nursing homes, or other medical agencies or institutions as necessary. I hereby authorize that information of my evaluation may be used for educational purposes. In these cases, PATHEOUS HEALTH will take steps to protect my privacy.

TO: PATHEOUS HEALTH I hereby authorize payment to PATHEOUS HEALTH IMAGING, LLC for the benefits otherwise payable to me but not to exceed the balance due of the agency's regular charges for these services. I understand I am financially responsible to this Agency for charges not covered by this authorization.

TO: Medicare: Patient's Certification: Authorization to release information and payment request, I certify that the information given to me in applying for payment under Title XVIII of the Social Security Act is correct. I authorize the release of all records required to act on this request. I request that payment of authorized benefits be made in my behalf.

TO: _____ (Insurance Carrier), I hereby authorize the release of all information required to act on this request. I request that payment of authorized benefits be made in my behalf for the above services rendered by PATHEOUS HEALTH.

Signed: _____ Date: _____ Witness: _____
Patient's Signature

Signed: _____ Date: _____ Witness: _____
Responsible Party or Guardian

Relationship: _____ Patient unable to sign. Date: _____ Witness: _____

*Verbal Authorization **given** by: _____ Relationship to patient: _____

*Verbal Authorization **taken** by: _____ Date: _____

* Verbal authorization may be taken by phone, and the responsible party must sign the document upon the next visit to the facility. A copy of the signed form should be faxed or emailed to the appropriate **PATHEOUS HEALTH** scheduling office once completed.