Consent, Authorization & Release of Information:

** If the patient cannot consent for him/herself,* ***CONSENT*** *from either the invoked Health Care Proxy (HCP) or legal guardian for the patient must be obtained.**

Patient Name: ___________________________________ DOB: ______________

MassTex Imaging, LLC has my consent to perform a Dysphagia Consultation and X-Rays including a Modified Barium Swallow Study (MBSS) and Esophageal Assessment to the Stomach.

I authorize insurance benefits to be paid directly to MassTex Imaging and acknowledge that I am responsible for any balance that may not be covered, including co-pays and deductibles.

MassTex Imaging, LLC has my consent to release Protected Health Information (PHI), medical records, portal access and reports as pertaining to the Dysphagia Consultation, Modified Barium Swallow Study (MBSS) and Esophageal Assessment to the Stomach, to my insurance company and the referring physician and referral source. Swallow studies may be used for research, publication, and/or educational purposes. No identifying information will be disclosed without specific written consent.

Please list anyone else, other than the referring physician / clinician you would like the information to be released to: (name & relation to patient)

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Please Complete Verbal **OR** Written Consent

Verbal Consent

Verbal Consent Given By: ____

Relation to Patient: ☐ Patient ☐ Guardian / POA ☐ Health Care Proxy

Printed Name & Title of Person RECEIVING Verbal Consent: ______________________________________

Signature of Person RECEIVING Verbal Consent: _________________________ Date Consent Obtained: __________

Written Consent

Printed Name of Person Giving Consent: ____

Relation to Patient: ☐ Patient ☐ Guardian / POA ☐ Health Care Proxy

Signature: ______________________________________ Date: ______________________________

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Form Version 2.4 – 6/15/2016