THERMAL IMAGING CENTERS
OF AMERICA

623-243-7100
thermalimagingcenters.com
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PATIENT CONSENT FORM

Name:____ DOB:______________
ADDRESS:____
CITY/STATE/ZIP:____
PHONE:____
EMAIL: ____
SCAN TYPE: _______Full Body _______Half Body _______Breast/Lymph _______Spot View
How did you learn about Thermography?_____________________________________
How were you referred to Thermal Imaging Centers of America™?__________________

I understand the report generated by my images is intended for use by a trained healthcare provider to assist in evaluation, diagnosis and treatment. I understand the report is not intended for use by individuals for self evaluation, diagnosis or treatment.

I understand the report will not tell me whether I have an illness, disease, cancer or any other condition but will be an analysis of the images with respect to the thermographic findings of the areas discussed in the report. By signing below, I knowledge and certify that I have read and understand the statements above and consent to the examination. I also authorize the release of information to the reading doctor and the receipt of information from the reading doctor in pursuit of comprehensive evaluation and treatment relating to the services provided by Thermal Imaging Centers of America/Total Thermal Imaging. I understand that my report will be sent to me via electronic mail. If an email address is not available, my report will then be sent to me via US Postal Service.

Authorization to use or disclose protected health information is required by the privacy regulations. Thermal Imaging Centers of America and Total Thermal Imaging may not use or disclose protected health information without my consent.

I hereby authorize Thermal Imaging Centers of America and any of its employees to use or disclose any patient health information to the following person(s), entity(s) or business associates of: Total Thermal Imaging and/or Dr. Gregory Melvin, DC, BCCT (our primary reading doctor).

Patient information authorized to be disclosed: thermal images and related health history for the specific purpose of a report of thermal findings and impressions of set images.

I understand that it may be possible that my image(s) may be used for the purpose of marketing, training or education however, my identity will be protected according to HIPPA and other identity protecting regulations.

I understand that I have the right to refuse to sign this consent or revoke this authorization by sending a written notice to this office and that not signing or revoking will not affect previous reliance on the uses for the disclosure pursuant to this authorization. I also understand that if I do not sign this document, it will not impact my treatment, payment, enrollment in health plan or eligibility for benefits in any way.

Signature:____ Date:_________

Print Name:____