ACKNOWLEDGEMENT OF NOTICE OF PRIVACY PRACTICES

The Notice of Privacy Practices provides information about how we may use and disclose protected health information about you.

In addition to the copy we will provide you, copies of the current notice are available at any of our office locations.

I acknowledge that I have received the Notice of Privacy Practices.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Print Name Relationship to Patient

_____ _____
Patient's Date of Birth Account #

_____ Notice of Privacy Practices Given-Patient Unable to Sign

_____Notice of Privacy Practices Given-Patient Declined to Sign

_____Other_____

_____ _____
Signature of Premier MRI CT Representative Date

_____
Print Name

Please contact our Privacy Official should you have questions concerning this notice.