



**ACKNOWLEDGMENT OF
RECEIPT OF NOTICE OF PRIVACY PRACTICES**

By signing below, I acknowledge that I have received a copy of Medical Imaging's Notice of Privacy Practices. The Notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time and that I may obtain a revised copy of the Notice at the Clinic office where I receive health care services.

SIGNATURE: _____ **DATE:** _____

If you are not the patient, please fill out the following information:

Name: _____

Relationship to Patient: _____

Address: _____

Telephone: _____

Please furnish a copy of any conservator/guardianship papers with this form.