



DIAGNOSTIC RADIOLOGY

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES
FOR PROTECTED HEALTH INFORMATION

I acknowledge that I have received DIAGNOSTIC RADIOLOGY's Notice of Privacy Practices for protected health information.

Date: _____ Name of Patient: _____

Signature of Patient/Personal Representative

Documentation of Good Faith Effort to Obtain Written Acknowledgement

I made a good faith effort to obtain the patients written acknowledgement of our Notice of Privacy Practices for protected health information by (circle all that apply):

- Showing the patient the Notice of Privacy Practices in our office.
- Giving the patient a copy of our Notice of Privacy Practices to read prior to receiving any treatment or service.
- Asking the patient to sign this Acknowledgement Form.
- Other (explain in detail): _____

I was unable to obtain the patients written acknowledgement because (circle all that apply):

- The patient refused to sign this form.
- The patient would not sign the form because the patient said he/she did not understand the Notice.
- Other (explain in detail): _____

Date: _____ Name of Patient: _____

Signature of Patient/Personal Representative

NOTE: This written acknowledgement must be completed no later than the first date health care services or treatment is provided to the patient after April 14, 2003. This acknowledgement must be retained in the patients' permanent records.