UNIVERSITY MRI & Diagnostic Imaging Centers

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Patient Name:_____ Date: _____

Date of Birth: _____ Social Security #:_____

By signing this form, you acknowledge that we have provided you with our Notice of Privacy Practices which explains how your health information may be handled in various situations including your treatment, payment of your bill, and our healthcare operations. If your first date of service with us was due to an emergency, we must try to provide you with our Notice and get your written acknowledgement for the Notice as soon as we can once the emergency has passed.

In addition, I grant permission to the following person(s) to obtain my confidential medical information and medical records on my behalf:

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Name: _____ Relationship:_____

Should I need to alter the above information, I will give written instructions of any changes.

_____ _____

Patient's (or Legal Representative's) Signature Date

_____

Relationship of Legal Representative

For office use only

To be completed only if Acknowledgement is not signed.

1) Was the patient given a copy of the Notice of Privacy Practices? [ ] Yes [ ] No
2) Please explain why the patient was unable to sign this Acknowledgement and our efforts to try to obtain the patient's signature:

_____

_____

_____ _____

Name/Title/Location Date

Please scan HIPAA NPP Acknowledgment Form into patient's account Image Tab titled HIPAA

Web Form