CHOICE
Diagnostic Imaging

Acknowledgement Of Receipt Of **"NOTICE OF PRIVACY PRACTICES"** *For Protected Health Information*

PLEASE PRINT. THANK YOU!

I acknowledge that I have received a copy of Choice Diagnostic Imaging's **"Notice of Privacy Practices"** for Protected Health Information on the date set forth below.

_____
Date of Receipt

_____
Print Patient Name

_____
If Under 18, Print Guardian/Parent Name

_____
Patient Signature *(Guardian/Parent If A Minor)*

FOR USE BY CHOICE DIAGNOSTIC IMAGING PERSONNEL ONLY

COMPLETE IF PATIENT ACKNOWLEDGEMENT IS NOT OBTAINED

An Acknowledgement of Receipt of Notice Of Privacy Practice was not obtained because:

☐ Patient refused to sign Acknowledgement

☐ Unable to gain signed Acknowledgement due to communication/language or other barrier

☐ Patient was unable to sign Acknowledgement due to communication/language or other barrier

☐ Other: Please include reason _____

_____

_____

_____ _____
Signature of Choice Diagnostic Imaging Representative Date