EXPRESS MEDICAL IMAGING

630

PRIVACY PRACTICES RECEIPT ACKNOWLEDGEMENT

I have received the HIPAA NOTICE OF PRIVACY PRACTICES of Express Medical Imaging and have been provided an opportunity to review the information.

_____ _____

Printed Name Date of Birth

_____ _____

Signature Date

Please list the following people that you give Express Medical Imaging permission to release your detailed medical information to. If you choose not to release your medical information, please write NONE below.

(Please print)

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____