



Acknowledgement of Receipt of Privacy Notice (HIPAA)

I have been presented with a copy of SDI Diagnostic Imaging's **Notice of Privacy Policies**, detailing how my information may be used and disclosed as permitted under federal and state law.

Signed _____ Date _____

If not signed by patient, please indicated relationship to patient (e.g., spouse) and reason patient did not sign.

Relationship: _____ Witnessed by: _____

Reason Patient Did Not Sign: _____

Please list the person(s) you would like to have access to your records, other than you or your doctor.

I hereby give _____ permission to pick up my films/reports.

For Internal Use Only:

If patient or patients representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time) : _____

By: (name and title) : _____