Patient Acknowledgement of Receipt of the Notice of Privacy Practices *(Copies of our Priv. Prac. are at check-in window)*

I acknowledge that I have received a copy of the Clovis Open MRI Notice of Privacy Practices.

_____ _____
Signature Date

_____
Print Name of Patient

If you are signing as the patient's representative:

_____
Printed name of representative

_____
Describe how you are the patient's representative (for example: spouse, child, durable power of attorney for Healthcare – please provide a copy of the form, etc.)

Authorization for Release of Medical Information

I hereby give my permission for the person(s) listed below to receive information about my care,

NAME: RELATIONSHIP: PHONE/FAX #:

_____

_____

_____

Signature of Patient, or Guardian Date

_____ _____