CITY WIDE HEALTH FACILITY, INC.
RADIOLOGY DEPARTMENT

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ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

HIPAA STATEMENT: THIS NOTICE DESCRIBES HOW HEALTH INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are required by law to protect the privacy and confidentiality of health information about you, which we call "protected health information," or "PHI" for short. We are required to explain how we may use PHI about you and when we can give out PHI to others. You have rights regarding PHI about you as described in this Notice. We are required to follow the procedures in this Notice. We have the right to change our privacy practices and to make new Notice provisions effective for all PHI that we maintain by posting the revised notice at our location, making copies of the revised notice available upon request, and posting the revised notice on our website.

We must use and disclose your health information to provide information:

To you or someone who has the legal right to act for you (your personal representative). To the Secretary of the Department of Health and Human Services, if necessary, to make sure your privacy is protected. Where required by law.

We have the right to use and disclose health information to pay for your health care and operate our business, and for your treatment by your health care providers.

ANY OTHER USE OR DISCLOSURE OF PHI ABOUT YOU REQUIRES YOUR WRITTEN AUTHORIZATION.

PATIENT'S NAME: _____

I HAVE READ AND REVIEWED ATLANTIC RADIOLOGY IMAGING, PC PHI AND AGREE WITH THE TERMS STATED THEREIN.

SIGNATURE: _____ **DATE:**_____

[ ] PATIENT [ ] GUARDIAN: LIST RELATIONSHIP _____

THE PATIENT WAS PROVIDED AND EXPLAINED HIS HER PRIVACY RIGHTS.

EMPLOYEE SIGNATURE: _____ **DATE**_____