EASTERN RADIOLOGICAL ASSOCIATES®

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of Eastern Radiological Associate's **Notice of Privacy Policies,** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice, and I request the following restriction(s) concerning the use of my personal medical information:

_____

_____

_____

_____

Signed: _____ **Date:** _____

If not signed by the patient, please indicate relation to patient (e.g., spouse)

Relationship: _____ **Witnessed by:** _____

_____

Internal Use Only:

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

Presented on (date and time): _____

By: (name and title): _____