HIPAA Privacy Practice Form
Valley Radiology Consultants Medical Group

I hereby acknowledge that I have been offered a copy of Valley Radiology Consultants Medical Group's Notice of Privacy Practices. I further acknowledge that a copy of the current notice is posted in the reception, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Signed:______________________________________ **Date:**______________________

Print Name:___________________________________

If not signed by the patient, please include:

Relationship:

⇔ parent or guardian of minor patient

⇔ guardian or conservator of incompetent patient

Name of Patient:____

Yo reconozco que me han ofrecido una copia del aviso sobre las Practicas de Privacidad de Valley Radiology Consultants Medical Group. Tambien reconozco que hay una copia del aviso en la sala de espera, y que si hay cambios con el aviso de las Practicas sobre la Privacidad me ofreceran una copia en cada visita.

Firma:______________________________________ **Fecha:**______________________

Nombre:___________________________________

Si no es firmado por el paciente, favor indique:

Relacion:

⇔ padre/guardian del paciente menor

⇔ guardian/conservador del paciente incapacitado

Nombre del paciente:____

Print Name:___________________________________

For Office Use Only:

Date received:	**Processed by:**

Complete the following only if the Patient refuses to sign the Acknowledgement:

Efforts to obtain:____

____

Reasons for refusal:____