CNY Diagnostic Imaging Associates

CNY DIAGNOSTIC IMAGING
MEDICAL RELEASE FORM/PRIVACY POLICY

We use an automated reminder system to remind you of your appointment. This system will leave a message with whomever answers the call or on your answering machine. May we leave a message?

_____ Yes _____ No

Primary Phone Number:_____

Secondary Phone Number:_____

Email:_____

Please enter below (besides yourself/Doctor) who we may speak to regarding your care and/or pick up a copy of your images or reports:

Name:_____ Name:_____

I understand that CNY Diagnostic Imaging may need to obtain or release my PHI directly to or from healthcare facilities in order to treat, interpret or follow-up on my exam and complete quality assurance follow-up.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received CNY Diagnostic Imaging's Notice of Privacy Practices and that a copy has been made available to me.

_____ _____/_____/_____
Patient Name-Printed Date of Birth

_____ _____/_____/_____
Patient Signature Date

_____ _____/_____/_____
Signature of Parent or Guardian or Personal Representative Date

_____ _____/_____/_____
Witness Date