Nuclear Medicine Associates

1950 Court Street, Redding CA 96001 Tel (530) 225-8008 Fax (530) 225-8093

Acknowledgement of Receipt of Notice

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices.

☐Yes ☐ No I would like to receive a copy of any amended Notice of Privacy Practices by e-mail at: ______________________________.

Signed: ______________________ Date: ______________________

Print Name: ______________________ Telephone: ______________________

Date of Birth: ______________________ Account Number: ______________________

If not signed by the patient, please indicate your relationship to the patient:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of Patient: ______________________________

The following people have my permission to access my medical records:

Name:	Relation to Patient:	Restrictions:

For Office Use Only:

Signed form received by: ______________________________

Reasons for refusal: