

Physicians MRI, LLP
2625 Harlem Road, suite 110
Cheektowaga, NY 14225

Acknowledgement of Receipt of Notice of Privacy Practices

I certify that I have received a copy of the notice of Privacy Practices for **Physicians MRI, LLP**. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that might occur in my treatment, payment of my bills or in the performance **Physicians MRI, LLP** health care operations. The notice of Privacy Practices also describes my rights and **Physicians MRI, LLP** duties with respect to my protected health information. The Notice of Privacy Practices is posted in **2625 Harlem Road, Suite 110, Cheektowaga, New York 14225**.

Physicians MRI, LLP reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting that a revised copy be sent by mail, or by asking for one at the time of my next appointment (if applicable).

Signature of patient or representative: _____

Printed name of patient: _____

Date: _____ Relationship to patient: _____

Consent for the Use and Disclosure of Protected Health Information

By signing below, you consent to the use and disclosure of your protected health information by **Physicians MRI, LLP**, it's staff and it's business associates for treatment, payment and health care operations. For a more detailed description of uses and disclosures for these purposes, please view **Physicians MRI, LLP's** Notice of Privacy Practices (Notice). You have the right to review the Notice prior to signing this consent. The terms of this Notice are subject to change. If the terms do change, you may obtain a revised Notice by contacting **Physicians MRI, LLP** at (716) 897-2207 and requesting the revised Notice. We will post any revised Notice in a public area at 2625 Harlem Road, suite 110, Cheektowaga, New York 14225. You have the right to request that **Physicians MRI, LLP** restrict the use or disclosure of your protected health information, which **Physicians MRI, LLP** is otherwise permitted to use or disclose for treatment, payment and health care operations, although **Physicians MRI, LLP** is not required to agree to these restrictions. However, if **Physicians MRI, LLP** agrees to such restrictions, they are binding on it. You also further acknowledge that you understand that if the person(s) or entity(ies) that receives the information is not a health care provider or health plan covered federal privacy regulations, such information may be re-disclosed and is no longer protected by those regulations. Therefore, **Physicians MRI, LLP**, it's affiliates, agents, employees and physicians are hereby released from all liability arising from such disclosure of your protected health information. Finally, you have the right to revoke this consent in writing, except to the extents that **Physicians MRI, LLP** have taken action in reliance upon.

Agreed and acknowledged by:

(signature)

(date)