CASCADE RADIOLOGY
EXCELLENCE IN HEALTHCARE, IMAGING & SERVICE

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICE

PATIENT'S NAME_____ **D.O.B.**_____

1. I understand that as part of my health care, Cascade Radiology Consultants originates, records, and maintains health information about me, describing my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment, as well as, claims and, payment status. I understand that this health information may be used or disclosed by Cascade Radiology Consultants for treatment, payment, and health care operations.
For examples, my health information is:

- A basis for planning for my care and treatment.
- A means of communication among the many health professionals who contribute to my care.
- A source of information for applying my diagnosis and surgical information to my bill.
- A means by which a third party payor can verify that services billed were actually provided.
- A tool for routine health care operations, such as assessing quality and reviewing the competence of health care professionals.

2. I acknowledge that I have been provided with Cascade Radiology Consultants, Notice of Privacy Practices that provides a more complete description of information uses and disclosures and my rights regarding my medical information. I understand that Cascade Radiology Consultants reserved the right to change its Notice of Privacy Practices and at my request, will make available to me, a copy of any revised notice.

3. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment payment or healthcare operations, and that Cascade Radiology Consultants is not required to agree to the restrictions requested. If it does, it is bound by such restriction.

FOR CONFIDENTIAL COMMUNICATION:

CONTACT ME: By Phone By Mail By Email At Home At Work

_____ _____
Print Name of Patient or Legal Representative Date

_____ _____
Signature of Patient or Legal Representative Date

_____
Relationship to Patient (i.e. legal guardian power of attorney)