university medical imaging

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4901 Lac de Ville Blvd., Bldg. D. - Suite 140

Rochester, New York 14618

ACKNOWLEDGEMENT OF RECEIPT

I acknowledge that I have received a copy of the Practice's Privacy Notice bearing an effective date of April 14, 2003

_____ _____

Name of Individual (Printed) Signature of Individual

_____ _____

Signature of Personal Representative Relationship

Date Signed _____ /_____ /_____

I authorize the following person(s) to have access to my protected health information:

Name	Address	Phone	Relationship

For Office Purposes Only:

Medical Record #: ☐☐☐☐☐☐☐ D.O.B. _____ /_____/_____