MAIN STREET RADIOLOGY

ACKNOWLEDGEMENT

Patient Name: _____ DOB: _____ Age: _____

ACC: _____ MRN: _____ Referring Provider: _____

I, the undersigned, acknowledge the receipt of a complete copy of Main Street Radiology's HIPAA PRIVACY NOTICE concerning the use or disclosure of my protected health information ("PHI") and consent to the release of any medical information about me (and any others for whom I can give consent to the extent permitted by law) by Main Street Radiology's health care providers and its staff to any other health care providers involved in caring for me (or for others for whom I can give consent) to carry out diagnosis and treatment.

With your permission, we can communicate medical information to you or a designee by fax, e-mail and voicemail. Please sign and provide the appropriate information below allowing Main Street Radiology to do so on your behalf.

- ☐ Cell Phone Voicemail _____
- ☐ WorkPhone _____
- ☐ Fax _____
- ☐ Unencrypted E-Mail _____
- ☐ None of Above

MSR STAFF INITIAL _____

_____ _____

Signature of Patient or Authorized Representative Date

_____ _____

Name of Authorized Representative Relationship of Authorized Representative

Updated 6/1/2019