MEDICAL ARTS
RADIOLOGY
medartsrad.com

PATIENT PRIVACY SIGNATURE

Bay Shore Commack Huntington Massapequa
Patchogue Plainview Setauket West Islip

PRIVACY SIGNATURE

Dear Patient;
According to HIPAA Federal Regulations, each patient must be assured that his / her medical records are held in the strictest confidence. In order for Medical Arts Radiology Group, PC to comply with those regulations, we ask that you take a moment to complete the following questionnaire.

Your signature is required where requested.

With what individuals may we discuss medical history or test results?

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Name:_____ Relationship to Patient:_____

Where may we contact you?:

	(Circle One)		
Home Phone:	Y	N	Number:__(____)_____
Cell Phone:	Y	N	Number:__(____)_____
Work Phone:	Y	N	Number:__(____)_____
Email:	Y	N	E-mail address:_____

I understand that Medical Arts Radiology Group, PC will adhere to the regulations as outlined by HIPAA and will follow the guidelines I have outlined above.

I have received, Medical Arts Radiology Group, PC notice of Privacy Practices written in plain language. The notice provides in detail the use and disclosures of my protected health information that may be made by this practice, my individual rights, how I may exercise these rights and the practice's legal duties with respect to my health information.

I understand that Medical Arts Radiology Group, PC reserves the right to change the terms of its Notice of Privacy Practices and make changes regarding all protected health information resident at, or controlled by, this practice. If changes occur, this practice will provide me a revised Notice of Privacy Practices upon request. I also understand that without a signed consent from the patient, medical information will not be released to any unauthorized individuals.

Patient Name:_____ Date of Birth:_____

Signature of Patient:_____ Date:_____

Signature of Parent / Guardian:_____ Date:_____

(If Applicable)