RADIOLOGY CONSULTANTS OF LITTLE ROCK, P.A.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES (HIPAA)

By signing below, I acknowledge that I have received a copy of the Notice of Privacy Practices from Radiology Consultants of Little Rock, P.A. The notice describes how my health information may be used or disclosed. I understand that I should read it carefully. I am aware that the Notice may be changed at any time, and I may obtain a copy of the Notice at the location where I receive health care services.

I _____, hereby consent to allow the following person(s) access to information on my account that would otherwise be considered Protected Health Information.

1. _____ Relationship to patient: _____
2. _____ Relationship to patient: _____
3. _____ Relationship to patient: _____
4. _____ Relationship to patient: _____
5. _____ Relationship to patient: _____

PRINT PATIENT NAME: _____

SIGNATURE: _____ DATE: _____

Patient or Personal Representative