radiology partners

PRACTICE LOCATION: SINGLETON ASSOCIATES PA BAYLOR RADIOLOGISTS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing below, you are acknowledging that you have received a copy of the Notice of Privacy Practices.

_____ _____
Patient's Printed Name DOB

_____ _____
Patient's or Authorized Personal Representative's Signature Date

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Office Staff Use Only

Indicate why a sign acknowledgement could not be obtained:

- ☐ The patient refused to sign this form.
- ☐ Emergency situation prevented our practice from obtaining the patient's signature.
- ☐ The NPP was mailed or emailed to the patient per request.

  Mailing Address_____ Date mailed: _____

  Email Address: _____ Date emailed:_____

- ☐ Other Reasons:_____

_____

_____

_____ _____
Employee's Printed Name Employee's Signature

Date: _____

Scan into Patient's Electronic Medical Record