CNY DIAGNOSTIC IMAGING
MEDICAL RELEASE FORM/PRIVACY POLICY

We use an automated reminder system to remind you of your appointment. This system will leave a message with whomever answers the call or on your answering machine. May we leave a message?

_________ Yes __________ No

Primary Phone Number: ______________________________

Secondary Phone Number: ________________________

Email: ______________________________________

Please enter below (besides yourself/Doctor) who we may speak to regarding your care and/or pick up a copy of your images or reports:

Name: ____________________________ Name: _________________________

I understand that CNY Diagnostic Imaging may need to obtain or release my PHI directly to or from healthcare facilities in order to treat, interpret or follow-up on my exam and complete quality assurance follow-up.

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received CNY Diagnostic Imaging's Notice of Privacy Practices and that a copy has been made available to me.

________________________________ Patient Name-Printed	______/_______/_____ Date of Birth
________________________________ Patient Signature	______/_______/______ Date
________________________________ Signature of Parent or Guardian or Personal Representative	______/______/_______ Date
________________________________ Witness	_____/_______/______ Date