Diagnostic Imaging Specialists of Chicago, P.C.
Diagnostic ultrasound • Bone Densitometry • Digital Mammography

RECEIPT OF NOTICE OF PRIVACY PRACTICE FORM IN COMPLIANCE WITH FEDERAL NOTICE OF PRIVACY PRACTICES ACT
("HIPAA" – Health Insurance Portability and Accountability Act)
EFFECTIVE 4-14-03

I, _____ , hereby acknowledge the offer of or receipt of Diagnostic Imaging Specialists of Chicago, P.C. Privacy Practices Notice which provides detailed information about how Diagnostic Imaging Specialists of Chicago, P.C. may use and disclose my confidential medical information.

I understand that the physician has reserved a right to change his privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided to me or made available. Telephone questions about my confidential medical information (including billing questions) may be discussed with _____
Relationship (*ie. spouse, other family member, other physician*):_____

Signed: _____ Today's Date: _____

If you are not the patient, please specify your relationship to the patient: _____

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