

Nuclear Medicine Associates
1950 Court Street
Redding, CA 96001
(530) 225-8008

NOTICE RECEIPT ACKNOWLEDGEMENT

Purpose: This form is used to confirm that individual has received our Notice of Privacy Practice.

I, _____, acknowledge that I have received Nuclear Medicine Associates Notice of Privacy Practices. I have had full opportunity to read and consider the contents of this Notice of Privacy Practices.

Signature: _____ Date: _____

If this authorization is signed by personal representative on behalf of the individual, complete the following:

Personal Representative's Name: _____

Relationship to individual: _____

Print Patients Name: _____

Address: _____

Telephone: _____ E-Mail: _____

Pt. #: _____ SS #: _____