PRIVACY PRACTICE ACKNOWLEDGEMENT FORM

Breast Imaging of Savannah, LLC is committed to treating and using protected health information about you responsibly.

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment.
- Obtain payment from third-party payers.
- Conduct normal healthcare operations such as quality assessments and physician certifications.

By signing this form, I acknowledge that I have received the Breast Imaging of Savannah, LLC Notice of Privacy Practices. This represents a more complete description of the uses and disclosures of my health information. I have been given the right to review the Notice of Privacy Practices prior to signing this consent. I understand that Breast Imaging of Savannah has the right to change the Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that you have taken action relying on this consent.

Patient Name: ____Date: ___________________________

Signature of Patient or Legal Representative: ____

Relationship to patient: ____

Thank you,

Breast Imaging of Savannah, LLC

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