SAND LAKE IMAGING

Your Choice. The Clear Choice.

Acknowledgement of Privacy Practices
HIPPA Authorization

Patient Information

Patient Name: _____

DOB: _____ MRN: _____

I, _____, have been provided access to Sand Lake Imaging Center's Notice of Privacy Practices. I understand that I am entitled to a copy of these practices at my request.

Authorized Access

I furthermore acknowledge that I have the right to designate access to my Protected Health Information ("PHI") to anyone of my choosing. I hereby authorize disclosure of my PHI to the following individual(s):

Name:	Relationship:
_____	_____
_____	_____
_____	_____
_____	_____

Restrictions Requested by Patient

I request the following restriction(s) to releasing my PHI:

_____

_____

I understand I may revoke this authorization anytime by submitting a written request to the SLIC Privacy Officer, as per the office's Notice of Privacy Practices.

I understand that by signing this authorization, this information will be used by SLIC to make determinations for the release of my PHI. I also understand this authorization will remain in effect until I request an update and/or amendment.

_____ _____

Signature of Patient (or Parent/Guardian) Date/Time

_____ _____

Legal Representative (if applicable) Description of Authority