



RADIOLOGY
of Greater New Haven

Radiology of Greater New Haven
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Radiology of Greater New Haven

Written Acknowledgement of Receipt of Notice of Privacy Practices

Patient Name: _____ Date of Birth: _____

I, hereby acknowledge that I have received a copy of the Notice of Privacy Practices. I understand that if I have further questions or complaints I may contact the HIPAA Privacy Officer of Radiology of Greater New Haven. I also understand that I am entitled to receive updates upon request if the Radiology of Greater New Haven Notice of Privacy Practices is amended or changed in a material way.

Signature: _____ Date: _____



TO BE COMPLETED BY COVERED ENTITY IF UNABLE TO OBTAIN WRITTEN ACKNOWLEDGEMENT FROM PATIENT

On _____ (insert date), I attempted to obtain a written acknowledgement of receipt of the Notice of Privacy Practices from the above named patient, but was unable to because:

- Patient declined to sign this Written Acknowledgement
- Patient did not understand the request to sign the Acknowledgement
- Other (please specify): _____