RIVERSIDE RADIOLOGY & INTERVENTIONAL ASSOCIATES

Acknowledgement of Notice of Privacy Practices:

I hereby acknowledge that a copy of the Notice of Privacy Policy was made available to me by Riverside Radiology & Interventional Associates, Inc. on the date indicated below.

_____ Initial

Release of Information:

In order to ensure patient confidentiality, it is the policy of this office to release information only to the patient. If you wish for others to receive ANY information regarding your care, you must sign this release. By signing this release, you are giving us permission to release medical information to your referring physician, your insurance company and any other treating physician, therapists or hospitals.

If we are unable to reach you personally, do we have permission to leave a message on your voicemail or answering machine?

YES **NO**

I give permission for Riverside Radiology & interventional Associates to release my medical information to the following people:

NAME	**RELATIONSHIP TO PATIENT**	**PHONE NUMBER**

Release of Medical Information:

I hereby authorize to release the following information to Riverside Radiology & Interventional Associates, Inc.

_____ Imaging Reports

_____ Medical Records

I understand that the Radiologists of Riverside Radiology & Interventional Associates, Inc. would like to review the above films and/or information that were performed at your institution.

Patient Name (Print): _____ Date of Birth: _____

Patient or Guardian Signature: _____ Today's Date: _____