ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

SDI
Southern Diagnostic Imaging

1037 North Flowood Dr
Flowood, MS 39232

I hereby acknowledge that I received a copy of this medical practice's *Notice of Privacy Practices*.

Signed: _____ Date: _____

Print Name: _____ Telephone: _____

If not signed by the patient, please indicate relationship:

____ Parent or guardian of minor patient
____ Guardian or conservator of an incompetent patient
____ Beneficiary or personal representative of deceased patient

Name of patient: _____

FOR OFFICE USE ONLY:

Date signed form received by: _____

Acknowledgement refused:

Efforts to obtain: _____

_____

Reasons for refusal: _____

_____