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 and 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 physicians, therapists, or hospitals.

If we are unable to reach you personally, do we have your permission to leave a message on your voicemail or answering machine? YES NO

I give my permission for Riverside Radiology and Interventional Associates to release my medical information to the following people (in addition to those listed above):

NAME	RELATIONSHIP TO PATIENT

☐ **Initial**

Release of Medical Information:

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

________ Imaging Films and Reports

________ Medical Records

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

Patient's Name (Print): ____________________________ Date of Birth: __________

Patient or Guardian Signature: ____________________________ Today's Date: __________