

# Washington Imaging Services, LLC Acknowledgement of Receipt of Notice of Privacy Practices

By my signature I, \_\_\_\_\_, acknowledge that I received a copy of the Notice of Privacy Practices for Washington Imaging Service, LLC.

\_\_\_\_\_  
Signature of client (or personal representative)

\_\_\_\_\_  
Date

**If this acknowledgement is signed by a personal representative on behalf of the client, complete the following:**

Personal Representative's Name: \_\_\_\_\_

Relationship to Client: \_\_\_\_\_

Patient authorizes Washington Imaging Services, LLC (WIS) to obtain professional radiology interpretations from Overlake Imaging Associates, PC or it's designee (OIA), a separate entity. A portion of the WIS billing may represent fees due to OIA for OIA's services.

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### For Office Use Only

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I attempted to obtain written acknowledgement of receipt of our Notice of Privacy Practices, but acknowledgement could not be obtained because:

- Individual refused to sign
- Communications barriers prohibited obtaining the acknowledgement
- An emergency situation prevented us from obtaining acknowledgement
- Other (Please specify)

\_\_\_\_\_  
Employee Name

\_\_\_\_\_  
Date

This form will be retained in your medical record.