ADVANCED RADIATION CENTERS of NEW YORK
A DIVISION OF INTEGRATED MEDICAL PROFESSIONALS

Notice Of Privacy Practices Acknowledgement

By signing below, I hereby acknowledge receipt of the Notice of Privacy Practices of **Advanced Radiation Centers of New York** and consent to the uses and disclosures described in the Notice of Privacy Practices.

_____ _____ _____, 20____

Signature of Patient (or Personal Representative) Date of Signature

_____

Patient Name

_____

Relationship of Personal Representative to Patient

(*if applicable*)