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.

_____ _____

Signature of Patient (or Personal Representative) Date of Signature

_____

Patient Name

_____

Relationship of Personal Representative to Patient

(*if applicable*)