DIAGNOSTIC HEALTH ALASKA

Alaska's Home for Medical Imaging Since 1984

Acknowledgement of Receipt of Notice of Privacy Practices

Instruction to Patient:

1. Please fully complete, sign and date this form:
2. Please return this form to the Alliance location where services are performed.

I, _____, acknowledge that I have received the Notice of Privacy Practices issued by Alliance HealthCare Services or one of its subsidiaries or affiliates (collectively, "Alliance"). I agree that I will contact Alliance's Privacy Official with any questions that I may have concerning the Notice of Privacy Practices.

_____ _____

Signature of Patient Date

In the event the patient declines acknowledgement of receipt of Alliance's Notice of Privacy Practices, please describe below the good faith efforts used to obtain such acknowledgement and the reason why the acknowledgement was not obtained:

_____

_____

_____

_____

Signature: _____

Name: _____

Title: _____

Date: _____