

**Great Neck Stand Up MRI**  
600 Northern Boulevard, Suite 117  
Great Neck, NY 11021

**PATIENT ACKNOWLEDGMENT OF “NOTICE OF PRIVACY PRACTICES”  
RECEIPT**

I acknowledge that I have received a copy of Great Neck Stand Up MRI “Notice of Privacy Practices” (“Notice”) as required by the Health Insurance Portability and Accountability Act of 1996.

I understand that the Notice is intended to provide me with general information about Great Neck Standup MRI’s privacy practices with respect to Individually Identifiable Health Information, and that it is not a contract.

I further understand that all of the policies and information contained in the Notice are subject to change by Great Neck Stand Up MRI , with or without notice, in the accordance with applicable law.

\_\_\_\_\_  
(Signature of Patient)

\_\_\_\_\_  
(Print Name)

\_\_\_\_\_  
(Date)