RECEIPT OF NOTICE OF PRIVACY PRACTICES

By signing this form, you acknowledge receipt of the Notice of Privacy Practices of NOL, LLC, d/b/a Premier Radiology and RADS, LLC, d/b/a Premier Radiology & Pain Management Center. Our Notice of Privacy Practices provides information about how we may use and disclose your protected health information. We encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice at our next visit or request a copy by visiting our website : www. Premierradiology.com or by requesting a copy from our Privacy Officer at (615_ 851-6033.

If you have any questions about our Notice of Privacy Practices, please contact the Privacy Officer at (615) 851-6033.

I ____(PRINT NAME) acknowledge receipt of NOL, LLC, d/b/a Premier Radiology and RADS, LLC, d/b/a Premier Radiology & Pain Management Center's Notice of Privacy Practices.

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Patient's or Patient's Representative Signature Date

INABILITY TO RECEIVE NOTICE (Provider Use only)

To be completed only if no signature is obtained. If it is not possible to obtain the individual's acknowledgement, describe the good faith efforts made to obtain the individual's acknowledgement, and the reasons why the acknowledgement was not obtained.

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Signature of Provider Representative Date