NEW MEXICO SONOGRAPHICS, INC
Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by NEW MEXICO SONOGRAPHICS, INC (NMS) for the purpose of diagnostic or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations of NMS. I understand that diagnosis or treatment of me by any physician and/or ultrasonographer employed by NMS may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. NMS is not required to agree to the restrictions that I may request. However, if NMS agrees to a restriction that I request, the restriction is binding on NMS and any physician and/or ultrasonographer employed by NMS.

I have the right to revoke this consent, in writing, at any time, except to the extent that NMS has taken action in reliance on this consent.

The NMS's Notice of Privacy Practices has been provided to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my bills or in the performance of health care operations of NMS. The Notice of Privacy Practices for NMS is also provided in the Patient Waiting Area. This Notice of Privacy Practices also describes my rights and NMS's duties with respect to my protected health information.

NMS reserves the right to change the privacy practices that are described in the Notice of Privacy Practices. I may obtain a revised notice of privacy practices by requesting, in writing, that a revised copy be sent in the mail or asking for one at the time of my next appointment. I acknowledge receipt of the Notice of Privacy Practices.

NMS may call me with appointment reminders, cancellations, and may leave voice mail messages at my home or place of employment.

_____
Signature of Patient or Personal Representative

_____
Name of Patient or Personal Representative (please print)

_____
Date Signed

_____
Description of Personal Representative's Authority