

Heart & Vascular, PLC

NOTICE OF PRIVACY PRACTICE ACKNOWLEDGEMENT

Our Notice of Privacy Practices provides information about how we may use and release information about you. You have the right to review our notice before signing this form. As provided in our notice, you may obtain a revised copy by requesting a copy from our front desk staff.

You have the right to request that we restrict how protected health information about you is used or released for treatment, payment or health care operations. We are not required to agree this restriction, but if we do, we are bound to our agreement.

By signing below, you consent to our use and release of protected health information about you for treatment, payment or health care operations as described in our Notice. You have the right to revoke this consent, in writing, except if we have already made releases in reliance on your prior consent.

Patient Signature: _____
Patient Name: _____

Date: _____
Witness: _____

PATIENT METHOD OF DISCLOSURES

The HIPAA Privacy Rule gives the individual the right to request their confidential communications be made by alternative means, such as sending correspondence to the individual's office instead of the individual's home.

I wish to be contacted in the following manner (check all that apply)

___ Home Telephone _____
___ OK to leave message w/detailed info.

___ Written Communication
___ OK to mail to home address

___ Persons Allowed to Obtain your Health Information
1. _____
2. _____
3. _____

___ Work Telephone _____
___ OK to leave message w/detailed info.
___ Leave message w/call back number only

Patient Signature: _____
Patient Name: _____

Date: _____
Date of Birth: _____