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Board Certified in Cardiology, Echocardiography & Vascular Interpretation

ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE OF PRIVACY PRACTICES

Name: ____
(PRINTED NAME)

Signature of Patient Representative: ___________________________Relationship: __________

COMMUNICATION REGARDING YOUR PROTECTED HEALTH INFORMATION

List person(s) whom we may release your health information to: _________________________

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May we leave messages regarding appointment information, test results and/or treatments on your voicemail? **Yes** or **No** If yes, Phone # (_____) _____-_________

Signature: ____ Date: ____________________

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