



## HIPAA – Patient Acknowledgment Form

Our Notice of Privacy Practices (NPP) provides information about how Comprehensive Cardiology may use and disclose protected health information (PHI) about you. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

I give permission for Comprehensive Cardiology to:

Leave a message regarding an appointment

Leave a message regarding test results

Share medical information with:

(1) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

(2) Name \_\_\_\_\_ Relationship \_\_\_\_\_

Phone \_\_\_\_\_

I assume responsibility to inform the practice of any changes in the above information.

Print Patient's Name	Date
Patient's Date of Birth	Relationship to Patient
Signature	Today's Date

I have received the Notice of Privacy Practices

Signature \_\_\_\_\_

Relationship to patient \_\_\_\_\_ Date \_\_\_\_\_

January 5, 2015