PATIENT HIPAA ACKNOWLEDGEMENT AND DESIGNATION DISCLOSURE FORM

I. Acknowledgement of practice's notice of privacy practices:

By subscribing my name below, I acknowledge that I was provided a copy of the Notice of Privacy Practices (NNP), and that I have read (or had the opportunity to read if I chose) and understand the Notice of Privacy practices (NNP) and to its terms.

______________________ __________________ ____

Name | Date of birth | Signature of patient/guardian | Date

II. Designation of Certain Relatives; Close Friends and other Caregivers as my Personal Representatives:

I agree that the practice may disclose certain of my health information to a Personal Representative of my choosing, since such person is involved with my health care or payment relating to my health care. In that case, the Physician Practice will disclose only information that is directly relevant to the person's involvement with my health care or payment relating to my health care.

Print Name: _________________________________ Relationship to Patient: ___________________
Print Name: _________________________________ Relationship to Patient: ___________________
Print Name: _________________________________ Relationship to Patient: ___________________
Print Name: _________________________________ Relationship to Patient: ___________________

III. Request to Receive Confidential Communications Alternative Means:

As provided by Privacy Rule Section 164.522(b), I hereby request that the Practice make all communication to me by the alternative means that I have listed below.

Home Telephone Number

____

__Ok to leave message with detailed information
__Leave message with call back number only

Work Telephone Number

____

__Ok to leave message with detailed information
__Leave message with call back number only

Cell Telephone Number

____

__Ok to leave message with detailed information
__Leave message with call back number only

Written Communication Address

____

__Ok to leave message with detailed information
__Leave message with call back number only

____________________________ ____________________________________ ______________

Name | Signature of patient/guardian | Date

____ _______________________

Witness | Date

Cardiovascular Associates, The Heart Group Notice of Privacy Practices Acknowledgement- Effective: 9/20/2013

Revised on 8/17/23