HEART & VEIN CENTER P.A.

Acknowledgement of Receipt of Notice of Privacy Practices

I understand that as part of my health care, the practice originates and maintains paper and/or electronic records describing my health history, symptoms, examination, test results, diagnosis, treatment and any plans for future care or treatment (including but not limited to HIV/HEP reports). I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the health professionals who contribute to my care
- A source of information for applying my diagnosis and treatment information to my bill
- A means by which a third-party payer can verify that services billed were actually provided
- A tool for routine healthcare operations, such as assessing quality and reviewing the competence of staff
- I authorize Heart & Vein Center P.A. to download my medication history and prescription benefits

I have been provided the opportunity to review "Notice of Patient Information Practices" that provides a more complete description of information uses and disclosures. I understand that I have the following rights:

- The right to review the "Notice" prior to acknowledging this consent
- The right to restrict or revoke the use or disclosure of my health information for other uses or purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or health care operations

Restrictions:

I request the following restrictions to the use or disclosure of my health information:

_____

_____

_____

May discuss treatment, payment or healthcare operation with the following persons:

Please check all that apply: spouse ( ) children ( ) parents ( ) others ( )

Please list names: _____

_____

_____

_____

I understand that as part of treatment, payment or healthcare operation, it may become necessary to disclose health information to another entity. Examples: referrals to other healthcare providers, labs and/or other individuals or agencies as permitted or required by state or federal law.

I fully understand and accept the information provided by this consent.

_____ _____ _____

Signature Print Name Date

*If person other than patient is signing, are you: Parent, legal guardian, custodian or have power of attorney

yes ( ) no ( )

FOR OFFICE USE ONLY

( ) Patient refused to sign consent form