



CARDIOLOGY CONSULTANTS, LTD.

HIPAA Acknowledgement and Consent Form

I understand that, under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to: conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly, obtain payment from designated third-party payers and to conduct normal health care operations such as quality assessments or evaluations, and physician certifications.

I have been informed by you of your Notice of Privacy Practices containing a more complete description of the users and disclosures of my health information (available in office in print form or on the company website <http://www.cardioconsultantsva.com>). I have been given the right to review such Notice of Privacy Practices prior to signing this consent. I understand that this company has the right to change its Notice of Privacy Practices from time to time and that I may contact Cardiology Consultants, Ltd. at any of its office locations to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that Cardiology Consultants, Ltd. restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand Cardiology Consultants, Ltd. is not required to agree to my requested restrictions, but if Cardiology Consultants, Ltd. does agree, then it is bound to abide by such restrictions. I understand that I may revoke this consent in writing at any time, except to the extent that Cardiology Consultants, Ltd. has taken action relying on this consent.

I hereby authorize Cardiology Consultants, Ltd. to disclose Protected Health Information (PHI) to the following individual(s) (examples: spouse, brother, sister, etc.) **ONLY**:

Name	Telephone	Relationship
_____	_____	_____
_____	_____	_____
_____	_____	_____

Patient's Name

Date of Birth (MM/DD/YYYY)

Signed (Patient or Legal Representative for Patient)

Date

FOR OFFICE USE ONLY

We have made every effort to obtain written **acknowledgement** of receipt of our Notice of Privacy from this patient but it could not be obtained because: the patient refused to sign, due to an emergency situation it was not possible to obtain an acknowledgement, we weren't able to communicate with the patient or other (*Please provide specific details*) _____.

Employee Signature

Date