BAY AREA HEART CENTER

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NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT FORM AND PERMISSION TO RELEASE MEDICAL INFORMATION

PATIENT: _____ DOB: _____DATE:_____

Bay Area Heart Center has developed a comprehensive policy to preserve your confidential medical information also called "protected health information". This Notice of Privacy Practices is available for you to read and review in the lobbies of our offices. A printed copy of the notice is also available to you if requested.

I hereby acknowledge that this information has been made readily available to me, and I have had the opportunity to review the information contained therein.

In addition, I hereby given my permission for my Protected Health Information to be released, when necessary, to the following individuals, who are also my emergency contact(s):

Name: _____ DOB_____ Relationship to Patient: _____

Phone Number: _____

Name: _____DOB_____ Relationship to Patient: _____

Phone Number: _____

Name: _____DOB_____ Relationship to Patient: _____

Phone Number: _____

This information may include, but is not limited to, confirmation of appointments, testing results, medication changes, progress reports, etc. I may withdraw this permission at any time by informing the Bay Area Heart Center staff in writing.

_____ Date: _____
Patient's Signature

_____ Date: _____
Family/Significant Other Signature

OR
My Protected Health Information is not to be released to any individual.

_____ Date: _____
Patient's Signature

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