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Acknowledgement of Receipt of Privacy Notice

I have been provided with a Notice and Privacy Practices that provides me a more complete description of the uses and disclosures of certain health information. I understand that the Heart Clinic of San Antonio, P.A., reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy. I may request a copy of the updated Notice of Privacy Practices by calling my physician's office or requesting a copy in person at my appointment.

The duration of this authorization is indefinite unless otherwise revoked in writing. I understand that requests for medical information from persons not listed above will require a specific authorization prior to disclosure of any medical information.

Patient's Printed Name

Date of Birth

Patient/Legal Representative Signature

Date

Relationship to Patient

Witness

Date

The following names are of people I would like to be involved in or have access to my protected health information on a routine basis.

I give permission for the Heart Clinic of San Antonio, P.A., to share my protected health information with:

Name

Relationship

Name

Relationship

Name

Relationship