Comprehensive Cardiovascular
CCVMG
Leading the fight against heart disease

HIPAA PRIVACY FORM

I, _____ (print name) hereby request the use of the following confidential channels for the communication of information related to my personal health, treatment or payment for treatment.

This request supersedes any prior request for confidential channel communications I may have made.

Please select all that apply. Where you list more than one communication option, please indicate which you prefer.

I want you to contact me by telephone at_____

Do Do not leave messages on my answering machine.

Do Do not leave messages with any other person (**if yes please designate names below**)

- Spouse (print name) _____
- Child/Children (print name) _____
- Parent/s (print name) _____
- Sibling (print name) _____
- Other (print name) _____

I want you to contact me at the following address: _____
_____

E-Mail Address: _____

I will be responsible for communicating any changes or new restrictions to your office in writing.

PATIENT ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

You have the right to refuse to sign this Acknowledgement

I,_____ have received a copy of this office's
(Signature of Patient or Parent/Guardian)

NOTICE OF PRIVACY PRACTICES as required by federal law.

_____ _____
Print Patient's Name Date of Birth

_____ _____
Signature of Patient or Parent/Guardian Date