DOMINION CARDIAC CARE, P.C.

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ________________________________, have received a copy of the "Notice of Privacy Practices" for Dominion Cardiac Care, P.C. as provided in our notice, the terms of our notice may change. If we change our notice, you may obtain a revised copy. This notice is available in our office.

I understand that I may access my medical records at any time and that I may copy and/or inspect my PHI to be used or disclosed in accordance with Dominion Cardiac Care, P.C.'s policy. I understand that Dominion Cardiac Car, P.C. has the right to deny me access to my records on certain circumstances, in accordance with the law; however, in such instance they will provide me with a denial in writing.

AUTHORIZATION FORM FOR USE & DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

Our Notice of Privacy Practices provides information about how we may use and disclose protected health information (PHI) about you. It has been explained to the patient that disclosures may be made to family and friend related to the patient's health. I t has also been explained that we will only disclose information relevant to current treatment. Our patient has agreed that we will only disclose health care information to (list all that apply):

	In Person	By Phone
Spouse Name: ____	☐	☐
Parent(s) Name: ____	☐	☐
Sibling(s) Name: ____	☐	☐
Other/Relationship: ____	☐	☐

Expiration Date of Authorization: _____/_____/_____ or ☐ until otherwise specified

I, ____________________________________, authorize the use or disclosure of my PHI as specified in the Notice of Privacy Practices for Dominion Cardiac Care, P.C. I understand the purpose of the authorized use of disclosure of PHI is for use within Dominion Cardiac Care, P.C. or for authorized disclosure form another entity that is subject to the privacy rule to Dominion Cardiac Care, P.C. for treatment, payment or health care operation purposes. I also understand that id the organization authorized to receive my PHI is not a health plan or provider, that organization may disclose my PHI. In the event that this happens, I understand that my information may no longer be protected under the federal privacy rule and regulations. I understand that I may ask questions of Dominion Cardiac Care, P.C. if I do not understand any information contained in the Notice of Privacy Practices.

____ ____________________
(Printed Name of Patient) (Date)

____ ____________________
(Signature of Patient or Patient's Representative) (Date)

____ ____________________
(Printed Name of Patient's Representative) (Relationship)