FREEDMAN MEMORIAL CARDIOLOGY

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NOTICE OF PRIVACY PRACTICES

I, the undersigned patient of Freedman Memorial Cardiology, do hereby acknowledge that I have been given a copy or a copy has been made available to me for review of the Privacy Practices of this office. I understand that a copy of this document will always be available to me for my review. I understand that any questions I have can be directed to the privacy officer and/or my provider.

PLEASE CHECK ONE OF THE FOLLOWING:

_____I am satisfied to read and consult the office copies of the Notice of Privacy Practices that are always available to me.

_____I would like a personal copy to take home with me.

Patient Signature:_____Date:_____

Printed Patient Name:_____

If you are signing as the patient's representative:

Print your name:_____

Describe your authority:_____

PLEASE CHECK ONE OF THE FOLLOWING:

____ The following person is to be allowed my medical information by telephone:_____

OR

____ Do not release any medical information without written permission.