

FORT WAYNE CARDIOLOGY

HIPAA PRIVACY RECEIPT ACKNOWLEDGEMENT (Protected Health Information Access Form)

Date: _____

MR#: _____

Fort Wayne Cardiology's Notice of Privacy Policy has been offered to me. I understand I have the right to review the Notice of Privacy Policy prior to signing this document and by signing this document, acknowledge **only** that I have received the Notice of Privacy Policy.

The Notice of Privacy Policy for Fort Wayne Cardiology is also provided at the front desk of all of our offices.

Fort Wayne Cardiology reserves the right to change the privacy practices that are described in the Notice of Privacy Policy.

I may obtain a revised notice of privacy practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Printed Name of Patient

Printed Name of Personal Representative

Signature of Patient

Signature of Personal Representative

Patient Date of Birth

Description of Personal Reps. Authority

Check if the patient is a minor

I authorize the following individuals access to my Protected Health Information (PHI):

Name	Relationship	Date of Birth	Home Phone Number
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____
_____	_____	_____	_____

Patient Signature: _____

For authorization to release PHI to the above listed individuals.

The above named patient or personal representative of the patient was given Fort Wayne Cardiology's Notice of Privacy Policy on the date indicated, but either refused to sign the acknowledgement or did not return the acknowledgement.

Signature and Title of person providing the "Patient Notice of Privacy"

12-05

Forward this document to scanning