CENTRAL GEORGIA
HEART & VEIN CENTER

NOTICE OF HIPAA PRIVACY PRACTICE ACKNOWLEDGMENT

I understand that under Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information.

I understand that this form can and will be used to:

- Conduct, plan and direct my treatment and follow-up among the multiple healthcare providers who may be involved in that treatment directly and indirectly
- Obtain payment from third-party payers
- Conduct normal healthcare operations
- Send out any labs or images

I acknowledge that I have received your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may request in writing that you restrict how my private information is used or disclosed to carry out treatment, payment or health care operation. I also understand you are not required to agree to my requested restrictions, but if you do agree then you are bound to abide by such restrictions.

I agree to have my medical information released to the following spouse, family member, or individual:

Name: _____ Relationship: _____ Date: _____

Name: _____ Relationship: _____ Date: _____

Patient Name: _____

_____ _____

Signature of Patient or Personal Representative Date

_____ _____

Printed Name of Personal Representative Relationship to Patient