Cardiovascular Center, P.A.
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ACKNOWLEDGMENT OF RECEIPT OF OUR NOTICE OF PRIVACY PRACTICES

By signing below, I acknowledge that I have been provided with a copy of the **Cardiovascular Center, P.A.** Notice of Privacy Practices and have been advised of how health information about me may be used and disclosed by **Cardiovascular Center, P.A.** and how I may obtain access to and control this information.

X______________________________________
Signature of Patient or Personal Representative

X______________________________________
Print name of Patient of Personal Representative

X__________________________
Date

____
Description of personal representative's authority

1. May we leave a message on an answering machine? YES / NO

2. Preferred method of contact?

Home#:________________Cell#:____________________Work#:________________