PRIVACY PRACTICES ACKNOWLEDGEMENT

I have received the Notice of Privacy practices and I have been provided an opportunity to review it.

Signature: _____ Date: _____

It is the policy of Heart Care of the Poconos, P.C. and staff not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voicemail, cell phone and/or pager. Information will not be disclosed to unauthorized persons. Messages will not be left on answering machines unless the patient's name and/or telephone number is included in the recorded greeting.

I hereby authorize Heart Care of the Poconos, P.C. and/or their staff to leave medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes.

Please list phone numbers if you check "yes"

Home telephone: _____ Yes____ No____

Answering machine: _____ Yes____ No____

Work telephone: _____ Yes____ No____

Voice mail: _____ Yes____ No____

Cell phone: _____ Yes____ No____

Email: _____ Yes____ No____

May we send/fax/email medical records to another entity? Yes____ No____

If you would like to have information released to someone other than yourself please complete the following:
Please list names of all authorized persons:

Spouse: _____ Yes____ No____

Children: _____ Yes____ No____

Other names (please list relationship such as brother, sister, neighbor, etc.)
_____

_____

Please write a password for us to use to ensure we are speaking to the correct person when we contact you. Please give the password to any other persons who you have authorized to receive your information.

Password: _____