CARDIOVASCULAR SURGEONS, P.A.

CARDIAC ~ THORACIC ~ VASCULAR SURGERY

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICE NOTICE

I acknowledge that I have been provided a copy of the Cardiovascular Surgeons, PA "Notice of Privacy Practices for Protected Health Information" with an effective date of April 14, 2003. My signing this acknowledgement does not mean I have read the privacy notice. I understand that the delivery of my health care services will in no way be conditioned upon my signed acknowledgement. If I decline to sign this acknowledgement, Cardiovascular Surgeons, PA will continue to provide my treatment and will use and disclose my protected health information for treatment, payment and health care operations as necessary.

Patient's Signature: _____ Date: _____

Patient's Printed Name: _____ DOB: _____

CVS Witness: _____ Date: _____

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION TO A DESIGNATED INDIVIDUAL

This Authorization grants permission to individuals named below to: make or confirm appointments, have access to X-ray, laboratory, or test findings; have access to telephone communications and answering machine messages as well as other common means of communication; pick up sample medications, prescriptions and correspondence; be made aware of my diagnosis, prognosis, and treatment plans; have access to my financial health information; and accompany me to exam rooms during routine exams.

I hereby authorize Cardiovascular Surgeons, P.A. to use and disclose my individually identifiable health information as described above to the individuals listed below. I understand that **this authorization is voluntary**. I understand that once the information is disclosed to the individuals named below, federal privacy laws, statutes, acts and regulations may no longer protect the release information.

☐ Release information to Patient Only

Designated Party _____ Relationship to Patient _____

Address: _____ Phone: _____

Designated Party _____ Relationship to Patient _____

Address: _____ Phone: _____

The patient or the patient's representative must read and initial the following statements:

1. I understand that this Authorization will:
   _____ (Initial) Be effective for the lifetime of the patient unless revoked (See #2 Below)

2. _____ (Initial) I understand that I may revoke this Authorization at any time by notifying Cardiovascular Surgeons, P.A. in writing; however, if I do revoke the Authorization, it will not affect any actions taken by Cardiovascular Surgeons, P.A. prior to receipt of the revocation.

3. _____ (Initial) I understand that my treatment cannot be conditioned on whether I sign this Authorization.

Signature of patient or patient's representative: _____ Date: _____

(Form must be completed before signing or it will not be valid)