CardioVascular Solutions Institute

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ACKNOWLEDGEMENT AND RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I received a copy of this medical practice' Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I may request a copy of any amended Notice of Privacy Practices at each appointment.

_____ _____

Signed Print Name

_____ _____

Date Telephone

If not signed by the patient, please indicate relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient

Name and address of Patient: _____

_____

_____

NOTICE OF PRIVACY PRACTICES AND ACKNOWLEDGMENTS TRACKING INFORMATION

For Office Use Only:

Date received: _____ Processed by: _____

Practice Follow-up: (please circle) Yes No Date of Practice Follow-up: _____

Complete the following only if the patient refused to sign the acknowledgment:

Efforts to obtain: _____

Reasons for refusal: _____