PATIENT ACKNOWLEDGEMENT, CONSENT, RECEIPT FOR USE AND DISCLOSURE OF NOTICE OF PRIVACY PRACTICES

By signing this form I acknowledge the receipt / reading of HeartWell LLP, Notice of Privacy Practices (Reception Room plaque or brochure) which provides me with detailed information about how HeartWell LLP may use and disclose my protected health information (PHI) for the purposes of treatment, payment and health care operations (TPO).

In addition, by signing below, I understand that I hereby authorize the Practice to disclose my medical information so that the Practice may treat, seek payment from third parties for such treatment, and generally carry on the Practice's health care operations.

With this consent, the physicians of HeartWell LLP and its staff may call my home or alternative location and leave a message on voice mail, answering machine or in person, mail or email to my home or alternative location any items that assist in carrying out TPO, such as appointment reminders, lab results, prescription renewals, insurance discrepancies, patient statements and/or calls pertaining to my clinical care. I have the right to request how HeartWell LLP restricts how it uses or discloses my PHI to carry out my TPO. However, the practice is not required to agree to my requested restrictions, but if it does, is bound by this agreement.

I may revoke my consent in writing except to the extent the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, the physicians of HeartWell LLP may decline to provide treatment to me.

Patient's Signature:_____ Date:_____

Patient's Name:_____ DOB:_____
(Printed Name)

CONSENT TO DISCLOSE PROTECTED HEALTH INFORMATION TO FAMILY, FRIENDS AND / OR OTHER REPRESENTATIVES

NAME	RELATIONSHIP	TELEPHONE #

Patients Signature: _____ Date: _____