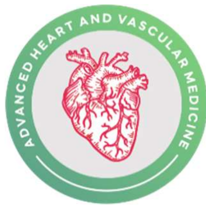

Advanced Heart and Vascular Medicine
Diagnostic and Interventional Cardiology
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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I, ___________________________________, have received a copy of Advanced Heart & Vascular Medicine's Notice of Privacy Practices.

____
Please Print Name

____ _____________________________________
Patient or Responsible Party Signature Date Signed

Consent to Release Information

I (the patient or responsible party) hereby authorize Advanced Heart & Vascular Medicine, it's physicians, agents, employees or representatives to discuss or release any or all patient information about me including but not limited to past and current medical information, billing information, appointment scheduling, prescriptions, etc. to the person(s) listed below.

___ Spouse Name:____
____ Parent(s) Name(s):____
____Child/Children Name(s):____
____ Other: Name(s):
____

Patient Name: _______________________________ Date of Birth: ____________ Date: _____________