LOURDES
HEALTH MANAGEMENT SERVICES ORGANIZATION

HIPAA-Patient Acknowledgement Form

Our notice of Privacy Practices (NPP) provides information about how long Lourdes Cardiology Services, PC may use and disclose protected health information (PHI) about you. The practice provides this form to comply with the Health Insurance Portability and Accountability Act (HIPAA). The NPP contains a Patient Rights section describing your rights under the law. Please review the Notice of Privacy Practices thoroughly before signing this acknowledgement form. In the event that terms of the Notice change, a revised copy will be made available to you.

By signing this form, you acknowledge that our Practice may use and disclose PHI about you for treatment, payment and healthcare operations. You have the right to request that we restrict how PHI about you is used or disclosed for treatment, payment or healthcare operations.

I give permission for Lourdes Cardiology Services, PC to:

Leave a message regarding an ☐ appointment and or ☐ Test Results

At_____(Home phone number) and/or

At_____(Cell phone number) and/or

At_____(Work phone number)

Share medical information with:

1. Name _____Relationship_____
   Phone _____
2. Name _____Relationship_____
   Phone _____

I assume responsibility to inform the practice of any changes in the above information.

Print Patients Name:	Date:
Patient's Date of Birth:	Relationship to Patient:
Signature:	Today's Date: