SAN DIEGO CARDIOVASCULAR ASSOCIATES

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

La Jolla Office ♥ 9834 Genesee Ave., Suite 300♥ La Jolla, CA. 92037
La Jolla Office ♥ 9850 Genesee Ave., Suite 940♥ La Jolla, CA. 92037
Encinitas Office ♥ 320 Santa Fe Dr., Suite 204 ♥ Encinitas, CA. 92024

I hereby acknowledge that I have been offered a copy of San Diego Cardiovascular Associates Notice of Privacy Practices. I understand that this document provides an explanation of the way in which my health information may be used or disclosed by San Diego Cardiovascular Associates. I understand that a copy of the current notice is available in the reception area and that additional copies are available to me upon my request. I am also aware that I can download a copy of the current Notice of Privacy Practices on the San Diego Cardiovascular Associates website at www.sdcva.com.

Patient Name: _____ **Date:** _____

Signature: _____ **Phone:** _____

If not signed by the patient, please indicate your name and relationship: _____

☐ guardian or conservator of an incompetent patient ☐ beneficiary or personal representative

☐ parent or guardian of minor patient

CONSENT FOR VERBAL RELEASE OF MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. This authorization does not have an expiration date but can be modified at any time in writing by the patient.
In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. Please indicate how you would like us to handle this:

☐ Call this number (___) _____-_____ to leave all health-related information.

Detailed confidential messages ☐ **may** ☐ **may not** be left at this number if answered by machine.

☐ Write only, **do not call** (This means your doctor can **NEVER** call you, even with test results or appointment reminders or cancellations).

☐ I authorize the practice to verbally release any or all information concerning my medical care to any family member.
OR
☐ Only discuss my health information with the following people

1. _____ 2._____ 3. _____