



Advanced Cardiology, Inc.

Dear Patient,

Advanced Cardiology Inc. is required by law to maintain the privacy of your health information and to provide you with a description of our legal duties and privacy practices regarding your health information. Attached you will find you copy of our Patient Privacy Policy. It fully describes how medical information about you may be used and disclosed and how you can get access to this information.

We are requesting that you acknowledge receipt of our Patient Privacy Police by signing and returning this form to us.

Please fill out the following regarding whom we may contact and/or with whom we may leave a message.

If yes, please check box, sign, date and list phone number in space provided

Self Only: Yes No

Spouse: Yes No

Name _____ Phonenumber: _____

Permission to leave message on voice mail/and or answering machine:

Yes No

Permission to contact you at work:

Yes No _____

Permission to call your cellular phone:

Yes No

Cell Phone Number: _____

Other: please list, sign and date

Person(s) authorized to receive healthcare information:

Name	Relationship/Phone Number
_____	_____
_____	_____
_____	_____
_____	_____

Patient Name

Signature

Date