Notice and Acknowledgement of Receipt of Privacy Policy- HIPAA

Acknowledgement:

I acknowledge that I have received CardioVascular Associates of Mesa's Notice of Privacy Practices.

____________________________________ ______________

Patient or Personal Representative Signature Date

____________________________________ ______________

Patient or Personal Representative Printed Name Date

If Personal Representative's signature appears above, please describe Personal Representative's relationship to patient:

You have the right to request restrictions or limitations on your health information used for treatment, payment or health care operations. You may request us to limit disclosure to someone involved in your care or in payment for your care by written request.

I hereby request the **nondisclosure** of my health information to the following individual/entity.

____ __________________________

Name Relationship

____ ________________

Patient or Personal Representatives Signature Date