Golden Empire Cardiology

Acknowledgement of Privacy Practices

I hereby acknowledge that I received a copy of this medical practice's Notice of Privacy Practices. I further acknowledge that a copy of the current notice will be posted in the reception area, and that I will be offered a copy of any amended Notice of Privacy Practices at each appointment.

Date ________ / ________ / ________ Signature ____

Print Name ____ Telephone ____

If not signed by the patient, please indicate relationship:

- ☐ Parent or guardian of minor patient
- ☐ Guardian or conservator of an incompetent patient
- ☐ Beneficiary or personal representative of deceased patient

Name of patient ____

Personal Representative Authorization

A personal representative is anyone that you would like for Golden Empire Cardiology to release your patient information to, including, but not limited to, prescription refills and/or samples, reasons for a particular visit, billing information, etc. If there are no names listed below we are assuming that you are declining your option to choose a personal representative. Upon doing so, please keep in mind that our office will not give out any information, including prescription refills, to anyone other than the patient or patient guardian.

- ☐ I do not wish to select a personal representative
- ☐ I authorize the following individual(s) to serve as my/patient's Personal Representative with full authority to access or authorize review, release and/or copying of my/patient's medical records:

1. ____
2. ____
3. ____
4. ____

I may revoke this request in writing, at any time except to the extent that action based on this authorization has already taken place.

Date ________ / ________ / ________ Signature ____

(Signature of Patient, Personal Representative of Patient, or Legal Guardian of Patient)

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