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Notice of Privacy Practices

Southwest Cardiology, Inc. patient acknowledgment:

I hereby acknowledge that I was given a copy of the Notice of Privacy Practices issued by Southwest Cardiology, Inc. on the date indicated below.

Signature

Print or Type Name

Date

* Name of Patient (if different from above)

* Relationship to patient

Witness signature

Date

Authorization for Telephone Contact

Due to the number of patients who have voicemail and/or answering machines, we need information about how to communicate with you.

Do you have an answering machine at your home? Yes No

If yes, may we leave a message regarding test results, appointments, surgery scheduling and/or billing matters? Yes No

Phone number: _____

Do you have voicemail at your job? Yes No

If yes, may we leave a message for you to return our call? Yes No

Phone number: _____

If you are not available, may we leave the above information with the spouse, relative, or another person? Yes No

If yes, list the name and phone number below:

Spouse _____

Phone _____

Other _____

Phone _____

Other _____

Phone _____

Patient Signature

Date