ACKNOWLEDGEMENT OF OUR NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received or have been given the opportunity to receive a copy of the Florida Heart Associates revised Notice of Privacy Practices. By Signing below, I am "only" giving acknowledgement that I have received or have had the opportunity to receive the revised Notice of Privacy Practices.

______________________________________ ______________________________

Patient's Name (Print) Date

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Patient's Signature

CONSENT TO DISCLOSE MEDICAL HEALTH INFORMATION

HIPAA

I hereby authorize the employees of Florida Heart Associates to disclose my protected health information as described on this form to the recipients listed below. I understand that when information is used or disclosed to pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization.

I understand and authorize my health care provider to use an automated telephone and/or e-mail system to use my name, address, and phone number; the name of my schedule treating physician; and the time and place of my scheduled appointment(s) for the limited purpose of contacting me to notify me of a pending appointment or other healthcare related communication. I also authorize my healthcare provider to disclose to third parties who answer my phone to limited protected health information regarding pending appointments, and to leave a reminder message on my voice mail system or answering machine. In addition, I authorize my healthcare provider to use a telephone message service to relay this information as well as protected health information necessary to respond to my immediate health issues.

______________________________________ ______________________________

Name Phone

______________________________________ ______________________________

Name Phone

______________________________________ ______________________________

Patient's Name (Print) Date

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Patient's Signature