

# Frisco Heart & Vascular Institute, P.A.

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I have been provided with a Notice of Privacy Practices that provides a complete description of the uses and disclosures of certain protected health information. I understand Frisco Heart & Vascular Institute, P.A. reserves the right to change their Notice of Privacy Practices and prior to implementation will provide an updated copy to me in writing.

### **Persons Authorized to Receive Information:**

The following names are of people I authorize to have access to my protected health information. I give permission for Frisco Heart & Vascular Institute, P.A. to share my protected health information with:

Name	Relationship
Name	Relationship
Name	Relationship

I authorize the person(s) listed above to receive information about appointments, treatments, and/or other information pertinent to my healthcare and relationship with Frisco Heart & Vascular Institute, P.A.

\_\_\_\_\_ I do NOT authorize any information to be disclosed to any other parties other than those outlined in the Notice of Privacy Practices.

### **Information Release to Other Healthcare Professionals:**

I authorize Frisco Heart & Vascular Institute, P.A. to release pertinent medical information to other healthcare professionals directly involved in my medical care. This includes lab results, radiology reports, physician notes, prescription information, treatment plans, etc.

### **Expiration Date of Authorization:**

This authorization does not expire unless revoked or terminated by the patient or patient's legal representative in writing.

### **Signatures:**

Signature of Patient or Legal Representative	Date
Printed Name of Patient or Legal Representative	Witness Signature