



NOTICE OF PRIVACY PRACTICES

ACKNOWLEDGEMENT

I understand that under the Health Insurance Portability & Accountability Act of 1996 (“HIPAA”), I have the right to privacy regarding my protected health information. I understand that this information will be used to carry out treatment, payment, and health care operations.

I acknowledge that I have received a copy of Pima Heart & Vascular’s Notice of Privacy Practices containing a description of these uses and disclosures of my protected health information and my individual rights with respect to my protected health information.

PATIENT NAME: _____

SIGNATURE: _____

DATE: _____

OFFICE USE ONLY

I have attempted to obtain the patient’s signature in acknowledgment of this Notice of Privacy Practices but was unable to do so as documented below:

Date: _____ Name: _____

Reason: _____