ACKNOWLEGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

My signature below acknowledges that I have received the Notice of Privacy Practices pamphlet and had the opportunity to ask questions regarding this notice.

Print Name:_____ Date:_____

_____

Signature

AUTORIZATION TO DISCLOSE INFORMATION TO A THIRD PARTY

I, _____, authorize **Port Charlotte Cardiology, Dr. Aneley Hundae, M.D., FACC,** to release my protected health information to the person(s) listed below under the circumstances indicated.

Please initial the information you wish to be shared:

☐ Without Limitations ☐ Financial Records ☐ Medical Records ☐ Only if I become incapacitated	Authorized Person (please print): _____ Relationship to patient: _____ Contact's Phone #: _____
☐ Without Limitations ☐ Financial Records ☐ Medical Records ☐ Only if I become incapacitated	Authorized Person (please print): _____ Relationship to patient: _____ Contact's Phone #: _____

_____

Signature Date

OR

I, _____, choose ***NOT*** to release any of my health information to individuals (including my spouse) at this time, except as required by law, as stated in the Notice of Privacy Practices.

Print Name:_____

Date:_____

_____

Signature Date

www.portcharlottecardiology.com

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