Arizona Heart and Arrhythmia Clinic LLC /Arizona Heart Clinic

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY PRACTICES & CONSENT FOR TREATMENT, PAYMENT AND HEALTH CARE OPERATIONS

I acknowledge that I have received a copy of the Notice of Privacy Practices for Arizona Heart and Arrhythmia Clinic LLC, or have been informed that the Notice is posted in the office and on the practice web site arizonaheartclinic.com

I consent to the use and disclosure of my Protected Health Information (PHI) by Arizona Heart and Arrhythmia Clinic, LLC (AHAC) for purposes of Treatment, Payment and Health Care Operations as described in the Notice. I understand that this consent remains in effect until I rescind it. I have the right to revoke my consent in writing at any time, but any such revocation does not apply to uses or disclosures occurring before the effective date of the revocation. I understand I have the right to request restrictions in how my PHI is used or disclosed to carry out Treatment, Payment and Health Care Operations, but that AHAC is not required to agree with or grant those requests.

To assist us in maintaining confidentiality when calling about your test results or similar PHI, please complete the checklist below indicating where we may contact you regarding such information. Check "N/A" if the contact method is "Not Applicable." In the second column, please **list all contact telephone numbers** (including area codes). In the far right column, be sure to indicate whether we may leave *confidential information* on your respective voice mail or answering machines. Please initial any mistakes or corrections. You may change your preferences at any time.

Finally, HIPAA guidelines prohibit us from leaving a confidential message with your spouse, family member or friend without your written permission. Therefore, you may wish to designate a specific individual (one person only) with whom we may use our discretion to discuss your PHI under limited circumstances. Ideally, that person should be the individual who would assume responsibility for your health care decisions in the event you became incapacitated (i.e. your legal "next of kin"- spouse, parent, eldest child, guardian, etc.).

If you specifically do not want us to share your PHI with anyone else, please also indicate that preference below.

Contact Method	Telephone #	AHAC May Contact Me via				AHAC, May Leave a Confidential Message on My					
Home Phone	( )		Yes		No		N/A	**Home Voice Mail**		Yes		No		N/A
Home Fax	( )		Yes		No		N/A	**Work Voice Mail**		Yes		No		N/A
Work Phone	( )		Yes		No		N/A	**Cell Voice Mail**		Yes		No		N/A
Work Fax	( )		Yes		No		N/A	Email is for limited communication only: (e.g. appointment reminders, office updates)						
Cell Phone	( )		Yes		No		N/A							
Email			Yes		No		N/A							
Email address														

I give permission for AHAC to use its discretion in disclosing my PHI to the following individual (limited to one person):

_____; _____; (_____)_____
YOUR DESIGNEE'S PRINTED NAME RELATIONSHIP TELEPHONE

___ I do not want my PHI discussed with anyone other than myself.

The AHAC Notice Of Privacy Practices is subject to change and revision from time to time. Any such changes will be posted in our office or on our web site as of the effective date.

I hereby acknowledge all of the above:

_____
Printed Name

_____
SIGNATURE OF PATIENT OR PERSONAL REPRESENTATIVE

Date: _____/_____/_____.

_____
RELATIONSHIP OF PERSONAL REPRESENTATIVE TO PATIENT

For Privacy Issues, Please Contact:

Arizona Heart and Arrhythmia Clinic LLC
Privacy Officer
4550 East Bell Road, Suite 158
Phoenix, AZ 85032
Office Phone: 602-923-2222
Office Fax: 602-482-0210