

MIDAMERICA HEART & LUNG SURGEONS

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

I hereby acknowledge that I have received a copy of MidAmerica Heart & Lung Surgeons Notice of Privacy Practices.

Signature of Patient

Date

I, _____, authorize Mid America Heart and Lung Surgeons to release information regarding my complete health record including procedures, test results, scheduling and billing to the follow persons:

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

_____ Relationship: _____

For internal use only

If patient/patient's representative refuses to sign acknowledgement, please document date and time notice was presented to patient and sign below.

ACKNOWLEDGEMENT OF GOOD FAITH EFFORT

Patient received a copy of our Notice of Privacy Practices and refused to acknowledge receipt at this time.

Signature of Patient

Date/Time Presented

Signature of Privacy Officer

Date

This is a permanent part of the medical record and shall be retained with the chart at all times.