



River Region Cardiology

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334-387-0948 Office 334-387-0955 Fax

PATIENT'S RIGHT TO AGREE TO INCLUSION OR OPT OUT FORM Questions to patients requiring a response to appropriately maintain their privacy

YES

NO

Do you wish for us, in the course of your care, to release information regarding you and your health information to:

- A family member;
- Other relative;
- Close personal friend (s); or
- A personal representative identified by you.

If yes, please identify by name:

ACKNOWLEDGEMENT OF RECEIPT OF PRIVACY NOTICE

I acknowledge that I have been provided a copy of the practice's

"NOTICES OF PRIVACY PRACTICES"

Which provides a description of the manner in which the practice may use and disclose my protected health information.....

Date: _____

Signature of patient or personal representative

Patient's name (please print)