IOWA HEART CENTER, P.C.

Acct # _____

Please Print Name: _____ Date of Birth: _____

▪ Acknowledgement of Receipt of Notice

By signing below you are acknowledging that you have received a copy of the Iowa Heart Center P.C. Notice of Privacy Practices as required by the Health Insurance Portability and Accountability Act of 1996.

▪ Permission for Verbal Disclosure

If you would like to give Iowa Heart Center P.C. staff permission to discuss your care with someone please indicate below.

I, the undersigned, authorize the Iowa Heart Center P.C. to verbally disclose my Protected Health Information to the following individual(s) or entities. I understand that this permission only applies to **verbal / spoken** communication to include but not limited to: discussion of my treatment plans, medications, test results, and upcoming procedures. I further understand that disclosure of copies of my medical record, or other written forms of my protected health information, will require my written authorization for each episode of release. This permission will become a permanent part of my medical record.

Name: _____ Ph# _____

Relationship: _____

Name: _____ Ph# _____

Relationship: _____

The individual / entity named above may receive oral disclosures about:

☐ All protected health information without restriction

☐ Other (specify): _____

▪ Permission for Iowa Heart Center to Leave a Message

Iowa Heart Center utilizes an automated system to call and confirm appointments. If an answering system picks up this call a message will be left automatically. Other than these appointment reminders, is it alright for Iowa Heart Center to leave messages containing our contact information?

☐ No- please do not leave a message on any answering system

☐ Yes- a message may be left on my home answering machine @ Ph# _____

☐ Yes- a message may be left on my work answering machine @ Ph# _____

☐ Yes- a message may be left on my Cell answering service @ Ph# _____

I understand that while verbal revocations will be accepted a written revocation will be necessary for documentation purposes. Other than revocation, any changes requested will require written notification to the Iowa Heart Center P.C. I also understand that any release made prior to my revocation which was in compliance with this authorization shall not constitute a breach of my rights to confidentiality.

Patient / Legal Representative Signature:

_____ Date: _____

Relationship if other than patient: _____