Cardiology Associates of Michigan, P.C.

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HIPAA Notice and Acknowledgement

I,_____, acknowledge that I have received the attached Notice of Privacy Practices.

Patient or Guardian Signature	Date

The following authorizations will remain in effect until revoked in writing by the patient or the patient's authorized personal representative.

In compliance with the Privacy Practices of Cardiology Associates of Michigan, P.C., I authorize Cardiology Associates of Michigan, P.C. and its agents to disclose and/or discuss my Private Health Information (PHI) with the following individuals:

Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient
Name	Relationship to Patient

I authorize Cardiology Associates of Michigan, P.C. and its agents to leave messages regarding my PHI on a telephone answering machine or voice mail service.

Please check appropriate box:

☐ Yes

☐ Yes, with restrictions:_____

☐ No

Patient or Guardian Signature

Date