



**CARDIOLOGY  
CONSULTANTS**

Jack D. Bargainer, M.D.  
David R. Blackwood, M.D.  
G. Noel Chant, M.D.

N. Daggubati, M.D.  
Larry Lin, M.D.  
Nikunj Patel, M.D.

Udaya Swarna, M.D.  
Gorman Thorp, M.D.  
Ren Zhang, M.D.

**Acknowledgement of Receipt of "Patient Notice of Privacy Rights"  
Summary Notice (9-29-10)**

**"THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND  
DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.  
PLEASE REVIEW IT CAREFULLY."**

As our patient, under HIPAA, the new federal privacy act, you have specific privacy rights. This notice is provided in 2 pages. This 1<sup>st</sup> page summarizes how we handle your health information, and contains the acknowledgement of receipt that we are required by law to attempt to obtain. The 2<sup>nd</sup> page contains the details about our privacy policies and procedures. We are required to have and provide a notice for our patients detailing how medical information about them may be used and disclosed and how you can get access to this information.

You have a right to review our notice before signing this acknowledgement. A copy of our "Patient Notice of Privacy Rights" is posted in our waiting room and is provided to all patients at their initial visit to our office beginning 4-14-03. The terms of our notice may change. Any change in our notice will be posted in our waiting rooms. This is a summary notice of your rights.

A summary of your rights includes your right to:

- a. restrict the use and disclosure of health care information (but your doctor is not required to grant this type of request)
- b. receive confidential communications in an alternate form or location
- c. inspect, copy, and amend protected health information (you may be billed for the cost of copying)
- d. know about any unauthorized disclosure of protected health information or data breach of our practice management system which involves your protected health information.
- e. have a copy of our patient privacy notice

**You must be given a copy of the "PATIENT NOTICE OF PRIVACY RIGHTS with REGARD TO  
HEALTH CARE INFORMATION", from our receptionist.**

**Signature Acknowledgement:**

I acknowledge the receipt of a copy of the "Notice of Privacy Practices" from Abilene Cardiology Consultants.

DATE	PATIENT PRINTED NAME	PATIENT SIGNATURE
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Patient Representative Signature (Required if minor or an adult who is unable to sign)	MEDICAL RECORD #
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**Documentation of Attempt to Obtain Acknowledgement of Receipt of Notice of Privacy Practices**

This notice and acknowledgement was mailed to the patient's home address on \_\_\_/\_\_\_/\_\_\_\_.  
The acknowledgement was not signed because:

- The patient refused to sign the acknowledgement
- The patient was undergoing emergency treatment
- \_\_\_\_\_ :Other

Signature: \_\_\_\_\_

Signature of staff member	Date
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