HIPAA

The ***Health Insurance Portability and Accountability Act*** of 1996 (HIPAA) is a federal law, which contains rules about how we can use your medical information with, and without, your prior permission. It also gives patients new rights with respect to the privacy of their medical information. We are obligated by law to make available to you our Notice of Privacy Practices, which explains our duties and your rights, and to get a written acknowledgement from you that you have received this information. ***The Receptionist has copies of the Notice of Privacy Practices if you would like to review them.***

To learn more about HIPAA, visit the *United States Department of Health and Human Services* website at: http://www.hhs.gov/ocr/privacy/hipaa/administrative

☐ **I understand a copy of the Cardiology Associates of Princeton's Notice of Privacy Practices is available for my review.**

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This form authorizes the doctors and staff of Cardiology associates of Princeton, PA to discuss your protected health information with those you have listed below.

I give Cardiology Associates of Princeton, PA authorization to disclose my protected health information and/or account records to the individual(s) or organization listed below. I understand that unless I state otherwise, ***ALL*** information may be discussed or released. *(please print)*

First Name:_________________________________ Last Name:___________________________________

First Name:_________________________________ Last Name:___________________________________

Name of Organization:____

Your office may leave information on my: ***Home*** ☐**yes** ☐ **no or *Cell*** ☐ **yes** ☐ **no**

The patient has the right to revoke this authorization in writing at anytime, accept to the extent that action has been taken in reliance on this authorization. This authorization will remain in effect unless otherwise revoked by the patient.

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Patient's Signature **Date**