Valley Heart Associates
KLEE & STEVENSON

PATIENT NAME: _____

DOB: _____ DATE: _____

Please use blue/black ink

NOTICE OF PRIVACY PRACTICES ACKNOWLEDGEMENT

Valley Heart Associates follows the guidelines as stated in our Notice of Privacy Practices. Please acknowledge by signing below that you have been provided a copy of Valley Heart Associates *Notice of Privacy Practices*.

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

I authorize the release of photocopies of the following medical records and/or x-ray films in the possession or control of Valley Heart Associates, its employees and/or agents. FOR THE PURPOSE HEREOF, "MEDICAL RECORDS" and "X-RAY FILMS" SHALL INCLUDE ALL CONFIDENTIAL HIV-RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL COMMUNICABLE DISEASE RELATED INFORMATION (AS DEFINED IN A.R.S. SECTION 36-661), CONFIDENTIAL ALCOHOL OR DRUG ABUSE RELATED INFORMATION (AS DEFINED IN 42 (FR SECTION 2.1 ET SEQ), AND CONFIDENTIAL MENTAL HEALTH DIAGNOSIS/TREATMENT INFORMATION.

I authorize release of medical information to the entities indicated below. I understand that confidentiality cannot be guaranteed.

Physicians:
Family Members (please list name and relationship):
Can we contact you using the following personal electronic devices? Voicemail or Answering Machine: YES NO Fax: YES NO (if yes, fax number) _____ Email: YES NO (if yes, address) _____
Can we contact you using MedVoice, our automated attendant? (please see MEDVOICE informational document for a complete explanation of the system) MedVoice: YES NO

ASSIGNMENT OF BENEFITS/FINANCIAL AGREEMENT

I authorize release of all medical information that is pertinent to my medical care and necessary to process my insurance claims. I assign all medical and/or surgical benefits including major medical benefits to which I am entitled to Valley Heart Associates. This assignment will remain in effect until revoked by me in writing. A photocopy of this assignment is to be considered as valid as the original.

I understand that I am financially responsible for all charges. In the unfortunate event that an account is given to a collection agency or to an attorney, for collection, then the patient/responsible party shall pay to Valley Heart Associates all costs of collection, including reasonable attorney's fees and court costs, in addition to other amounts due Valley Heart Associates. I have read this information and agree with this policy.

I have read and understand the PRIVACY PRACTICES, AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS and ASSIGNMENT OF BENEFITS/FINANICAL AGREEMENT contained herein.

Patient Signature: _____ **Date:**_____