PATIENT NAME: ______________________________

Please use blue/black ink DOB: _____________ DATE: ______________

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) __________________________

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:**____________________