CARDIOVASCULAR CARE CENTER &CRC
CARE IS OUR MIDDLE NAME

1372 Wellbrook Circle NE, Conyers GA 30012
Phone: 470-500-CARE (2273) Fax: 470-289-5440

HIPPA RECEIPT OF ACKNOWLEDGMENT

I understand and have been provided with a "Notice of Information Practice" that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the practice reserves the right to change their notice and practices. I understand that I have the right to object to use of my health information for direct purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the practice is not required to agree to the restriction requested. I understand that I may revoke this consent in writing, except to the extent that the practice has already taken action in reliance thereon.

Patient Name: _____

Patient Signature: _____

Date: _____

Witness Name: _____

Witness Signature: _____

Date:_____