



**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES**

My signature below acknowledges that I have received the Notice of Privacy Practices pamphlet and had the opportunity to ask questions regarding this notice.

Print Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature \_\_\_\_\_

**AUTHORIZATION TO DISCLOSE INFORMATION TO A THIRD PARTY**

I, \_\_\_\_\_, authorize **Port Charlotte Cardiology, Dr. Aneley Hundae, M.D., FACC**, to release my protected health information to the person(s) listed below under the circumstances indicated.

Please initial the information you wish to be shared:

<input type="checkbox"/> Without Limitations <input type="checkbox"/> Financial Records <input type="checkbox"/> Medical Records <input type="checkbox"/> Only if I become incapacitated	Authorized Person (please print): _____ Relationship to patient: _____ Contact's Phone #: _____
<input type="checkbox"/> Without Limitations <input type="checkbox"/> Financial Records <input type="checkbox"/> Medical Records <input type="checkbox"/> Only if I become incapacitated	Authorized Person (please print): _____ Relationship to patient: _____ Contact's Phone #: _____

Signature \_\_\_\_\_

Date \_\_\_\_\_

**OR**

I, \_\_\_\_\_, choose **NOT** to release any of my health information to individuals (including my spouse) at this time, except as required by law, as stated in the Notice of Privacy Practices.

Print \_\_\_\_\_

Name: \_\_\_\_\_

Date: \_\_\_\_\_

Signature \_\_\_\_\_

Date \_\_\_\_\_

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