

# KSC Cardiology, P.A.

We manage the world of Cardiovascular Disease



## HIPAA Acknowledgement and Consent Form

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**I understand that under the Health Insurance Portability and Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I understand that this information can and will be used to:**

- **Conduct, plan and direct my treatment and follow-up care among the multiple healthcare providers who may be involved in that treatment directly or indirectly.**
- **Obtain payment from designated third-party payers.**
- **Conduct normal health care operations such as quality assessments or evaluations and physician certifications.**

**I have been informed by you of your Notice of Privacy Practices containing a more complete description of the uses and disclosures of my health information (available in the office in print form). I have reviewed such Notice of Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices prior to signing this consent, and acknowledge that I have studied the Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time, and that I may contact this organization at any time at the address above to obtain a current copy of the Notices of Privacy Practices.**

**I understand that I may request in writing that this organization restrict how my private information is used or disclosed to carry out treatment, payment or health care operations. I also understand the organization is not required to agree to my requested restrictions, but if the organization does agree, then it is abounded to abide by such restrictions.**

**I understand that I may revoke this consent in writing at any time, except to the extent that the organization has taken action relying on this consent.**

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\_\_\_\_\_  
**Patient Name :**

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

\_\_\_\_\_  
**Patient Signature :**

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