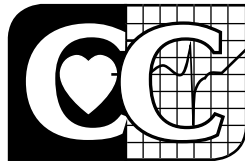


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Cardiac Consultants P.C.

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Jerry C. Luck, M.D.
Stephanie Cristoica, MSN, CRNP

PATIENT NAME _____
ACCOUNT # _____
DATE OF BIRTH _____

PRIVACY PRACTICES

NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the **Cardiac Consultants P.C.** Notice of Privacy Practices that describes how my medical information may be used or disclosed as required by federal law.

I have previously received a copy of the **Cardiac Consultants P.C.** Notice of Privacy Practices.

Signature

Date

PERMISSION TO DISCUSS MEDICAL INFORMATION

The privacy of your medical information is very important to us. If you wish us to discuss information about your medical condition to your family, friends, caregivers, or others, please indicate this by completing the information below.

I, _____, permit the discussion of my healthcare information for the purpose of communicating results, findings, care decisions and billing/payment information to the following individuals:

Name

Relationship

Name

Relationship

Name

Relationship

Name

Relationship

I understand that medical practice personnel will use their professional judgment to determine if the discussion is in my best interest if I am not present, incapacitated or in an emergency situation and that this authorization will remain in effect until revoked by me in writing.

Signature

Date

Cardiac Consultants P.C. Witness

Date