HIPAA Acknowledgement Form

Patient Name: _____
Date of Birth: _____

This acknowledgement confirms that I have received and reviewed the Notice of Privacy Practices provided by AMS Cardiology which outlines how my health information may be used and disclosed, and how I can access this information.

I understand that:

- The Notice of Privacy Practices may be amended at any time.
- I may request a copy of the current notice at any time.
- I have the right to request restrictions on how my health information is used or disclosed.

I acknowledge receipt of or have been offered a copy of the Notice of Privacy Practices.

Signature of Patient or Legal Representative:

Date: _____

Printed Name of Legal Representative (if applicable):

Relationship to Patient:
