Patient's Name: (please print) _____
Date of Birth: _____
Social Security Number: _____

Acknowledgement of Receipt of Notice of Privacy Practices

I acknowledge that I received a copy of Cardiovascular Consultants of KS, PA Notice of Privacy Practices. By signing, I understand that my medical information can only be discussed with my doctors and myself.

X _____ _____
Patient Signature Date

Release of Medical Information

If I would like my medical information released with anyone other than my doctor and myself, they must be listed below:

Name	Relationship to Patient

_____Patient elected not to allow release of medical information to any other person / persons other than themselves or their doctor.

Signature of Patient / Legal Representative: _____

Date: _____