# SAN DIEGO CARDIOVASCULAR ASSOCIATES

## ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

**La Jolla Office ♥ 9850 Genesee Ave., Suite 780♥ La Jolla, CA. 92037**
**Encinitas Office ♥ 320 Santa Fe Dr., Suite 204 ♥ Encinitas, CA. 92024**

I hereby acknowledge that I have been offered a copy of San Diego Cardiovascular Associates Notice of Privacy Practices. I understand that this document provides an explanation of the way in which my health information may be used or disclosed by San Diego Cardiovascular Associates. I understand that a copy of the current notice is available in the reception area and that additional copies are available to me upon my request. I am also aware that I can download a copy of the current Notice of Privacy Practices on the San Diego Cardiovascular Associates website at www.sdcva.com.

**Patient Name:** _____ **Date:** _____

**Signature:** _____ **Phone:** _____

If not signed by the patient, please indicate your name and relationship: _____

## CONSENT FOR VERBAL RELEASE OF PROTECTED HEALTH INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of the Practice to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. This authorization can be modified at any time in writing by the patient. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived. Please indicate how you would like us to handle this:

I hereby name the following individual as my personal representative:

Designee Name: _____ Relationship to patient: _____

Phone number (___) _____

Detailed confidential messages ☐ **m*ay*** or ☐ ***may not*** be left at this number if answered by machine.

By signing below I authorize the practice to verbally release any or all information concerning my medical care to my designee. I understand and authorize my designee to have access to my Protected Health Information (PHI) in order to have the following communication related to my healthcare with SDCVA.

Designee will be able to make, change or confirm appointments.
Speak with a healthcare provider and/or staff regarding my medical care coordination.
Speak with the Business Office regarding billing.
Grant proxy access to my healthcare records in the ***My Scripps*** patient portal.

**Patient Name:** _____ **Signature:** _____

**Date:** _____

If not signed by the patient, please indicate your name and relationship: _____