

# Institute for Cardiovascular Disease, P.A.

2301 NW 87<sup>TH</sup> AVE. Suite 502 – DORAL, FL. 33172

## PATIENT INFORMATION

LAST NAME <i>APELLIDO:</i> _____	FIRST NAME <i>NOMBRE:</i> _____		
DATE OF BIRTH <i>FECHA DE NACIMIENTO:</i> _____	AGE <i>EDAD</i> _____	SEX <i>SEXO</i> _____	MARITAL STATUS <i>ESTADO CIVIL</i> _____
ADDRESS <i>DIRECCION:</i> _____	CITY <i>CIUDAD:</i> _____	ZIP CODE <i>CODIGO</i> _____	
PHONE # <i>TELEFONO:</i> _____	CELL # <i># CELULAR</i> _____		
EMERGENCY CONTACT <i>FAMILIAR CERCANO:</i> _____	RELATIONSHIP TO PATIENT <i>RELACION CON PACIENTE :</i> _____		
PHONE # <i>TELEFONO:</i> _____	ADDRESS <i>DIRECCION:</i> _____		
MEDICARE # <i># DEL MEDICARE:</i> _____	MEDICAID # <i># DEL MADICAID:</i> _____		
OTHER INSURANCE <i>OTRO SEGURO:</i> _____			
POLICY # <i># DE LA POLIZA:</i> _____	SOCIAL SECURITY # <i># SEGURO SOCIAL:</i> _____		
KNOWN ALLERGIES <i>ALERGIAS CONOCIDAS:</i> _____			
REFERRED BY DR. <i>REFERIDO POR EL DR.:</i> _____	DATE <i>FECHA:</i> _____		

## EMPLOYMENT INFORMATION

PLACE OF EMPLOYMENT <i>LUGAR DEL TRABAJO:</i> _____		
ADDRESS <i>DIRECCION:</i> _____	CITY <i>CIUDAD:</i> _____	ZIP CODE <i>CODIGO</i> _____
PHONE # <i>TELEFONO:</i> _____	PHONE # <i># TELEFONO</i> _____	
OCCUPATION <i>PROFESION:</i> _____	LANGUAGE <i>IDIOMA</i>	English <input type="checkbox"/> Español <input type="checkbox"/> Creole <input type="checkbox"/> Other <input type="checkbox"/>

**Request for Alternative Means of Communications  
 Authorization for and Request for Restrictions on Use and  
 Disclosure of Protected Health Information  
 Acknowledgement of Receipt of Notice of Privacy Practices**



**Institute For  
 Cardiovascular  
 Disease**

**Patient Information**

Name	Date of Birth	Soc. Sec. Number	Home Phone
Street Address		City, State, Zip Code	Work Phone

**Alternative Means of Communication**

I wish to receive communications from the Institute for Cardiovascular Disease (the "Institute") through an alternative method or at any alternative address, as indicated and subject to the restrictions specified below.

Email Address	Cell Phone Number	Other (please specify)	Alternative mailing address
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**Authorization for Disclosure of Protected Health Information**

I acknowledge that the Institute may use and disclose my Protected Health information for the purposes of treatment, payment, and operations as described in the Notice of Privacy Practices. I also acknowledge that my Protected Health Information may be disclosed by other providers and/or facilities to the Institute for the purposes of treatment, payment, and operations.

**Restrictions on Use of Protected Health Information**

I request the following restrictions on the use and/or disclosure of my Protected Health Information (please be as detailed as possible). If the Institute agrees to my requested restriction, that agreement will not prevent the Institute from making uses or disclosures as otherwise permitted or required under the HIPAA Privacy Rule or the Institute's Notice of Privacy Practices. If the Institute's Privacy Officer agrees to my requested restriction, the Institute may later terminate that agreement by informing me.

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**I understand that:**

- Protected Health Information may include information and records protected under Federal and State Law, such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
- I may revoke this authorization at any time in writing. If I do, it will not have any effect on any actions taken by the Institute prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
- The Institute may use and/or disclose Protected Health Information without my authorization as permitted or required under the HIPAA Privacy Rule and the Institute's Notice of Privacy Practices.
- I may receive a copy of this form after I sign it.

*I have read the above and authorize the disclosure of Protected Health Information as stated above.*

Signature of Patient or Personal Representative	Legal Relationship to Patient	Date
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**Acknowledgement of Receipt of Notice of Privacy Practices**

I have received a copy of the Notice of Privacy Practices

Signature of Patient or Personal Representative	Legal Relationship to Patient
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**For Office Use Only**

The Institute attempted to obtain written acknowledgement of receipt of the Institute's Notice of Privacy Practices, but was unable to because:

- Individual refused to sign     Communication barriers with patient     An emergency situation prevented the Institute     \_\_\_\_\_