Institute For Cardiovascular Disease

888-380-9550
2301 NW 87th Ave. Suite 502
Doral, Florida 33172

PATIENT INFORMATION

Last Name *(Apellido)*: _____ First Name *(Nombre)*: _____

Date of Birth *(Fecha De Nacimiento)*: _____ Age *(Edad)*: _____ Sex *(Sexo)*: _____ Marital Status *(Estado Civil)*: _____

Address *(Direccion)*: _____ City *(Ciudad)*: _____ Zip Code *(Codigo)*: _____

Phone Number *(Telefono)*: _____ Cell Number *(Celular)*: _____

Emergency Contact *(Familiar Cercano)*: _____ Relationship to Patient *(Relacion con Paciente)*: _____

Phone Number *(Telefono)*: _____ Address *(Direccion)*: _____

Medicare Number *(Del Medicare)*: _____ Medicaid Number *(Del Madicaid)*: _____

Other Insurance *(Otro Seguro)*: _____

Policy Number *(De La Poliza)*: _____ Social Security Number *(Seguro Social)*: _____

Known Allergies *(Alergias Conocidas)*: _____

Referred By DR. *(Referido Por El Dr.)*: _____ Date *(Fecha)*: _____

EMPLOYMENT INFORMATION

Place of Employment *(Lugar Del Trabajo)*: _____

Address *(Direccion)*: _____ City *(Ciudad)*: _____ Zip Code *(Codigo)*: _____

Phone Number *(Telefono)*: _____ Occupation *(Profesion)*: _____

Language *(Idioma)*: ☐ English ☐ *Español* ☐ Creole ☐ Other

Institute For Cardiovascular Disease

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

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 methods or at any alternative address, as indicated and subject to the restrictions specifies below.

Email Address	Cell Phone Number

Other (please specify)	Alternative Mailing Address

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 HIPPA 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:

1. Protected Health Information may include information and record protected under Federal and State Law, such as: alcohol, drug abuse, mental health, AIDS or HIV testing or treatment.
2. 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.
3. The Institute may use and/or disclosure Protected Health Information without my authorization as permitted or required under the HIPPA Privacy Rule and the Institute's Notice of Privacy Practices.
4. 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*

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*

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
- ☐ _____