



Mid-Ohio Heart Clinic
680 Park Ave. West
Mansfield, Ohio 44906
(419) 524-8151

Acknowledgement of Receipt of “Notice of Privacy Practices”

Patient Name: _____ **Date of Birth:** _____

I hereby acknowledge, with my signature, that I have received the “Notice of Privacy Practices” of Mid-Ohio Heart Clinic. I understand the contents of the “Notice”, regarding the manner in which my personal health information/records may be used or disclosed by Mid-Ohio Heart Clinic.

Disclosure of Protected Health Information / Records

I hereby agree to authorize Mid-Ohio Heart Clinic to disclose the minimum amount of my health information/records, necessary for the continuity of my healthcare, and/or the payment thereof.

I hereby give authorization, to access of my protected health information/records, as described in the “Notice of Privacy Practices”, to individuals indicated below.

Please Initial to Indicate Who You Authorize

- _____ Self Only
- _____ All Family Members
- _____ Only the Following Family Members and/or Friends
- _____
- _____
- _____
- _____

Patient Signature

Date

OR

Responsible Individual / Guardian Signature

Relationship to Patient