



By signing this document, I acknowledge that I have been provided a copy of Capital Cardiology Consultants, P.C., Notice of Privacy Practices. This notice contains a complete description of my rights and the permitted uses and disclosures under the Health Insurance Portability and Accountability Act (HIPAA).

Signature: _____

Date: _____

In accordance with HIPAA rules, Capital Cardiology Consultants, P.C., is restricted from discussing your health information with other family members or persons unless you give your written consent.

By signing below, I grant Capital Cardiology Consultants, P.C. permission to discuss my protected health information with the following individuals:

Signature: _____

Date: _____