

**Acknowledgement of Receipt of Notice of Privacy Practices**

**Orange County Heart Institute and Research Center**

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1. I hereby acknowledge that I received a copy of this medical practice's Notice Privacy Practices. I further acknowledge that a copy of the current notice will Be posted in the reception area, and that I will be offered a copy of any Amended Notice of Privacy Practices at each appointment.
2. I would like to receive a copy of any amended Notice of Privacy Practices by E-mail at:

\_\_\_\_\_.

Signed: \_\_\_\_\_ Date: \_\_\_\_/\_\_\_\_/\_\_\_\_

Print Name: \_\_\_\_\_ Telephone: (    ) \_\_\_\_/\_\_\_\_

If not signed by the patient, please indicate:

Relationship:

- Parent or guardian of minor patient
- Guardian or conservator of an incompetent patient
- Beneficiary or personal representative of deceased patient

Name of Patient: \_\_\_\_\_