
**ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AT
TIDEWATER HEART INSTITUTE**

Tidewater Heart Institute reserves the right to modify the privacy practices outlined in this notice.

I have received a copy of the Notice of Privacy Practices

(name of patient – print or type)

(signature of patient)

(date)

(signature of patient representative – required if the patient is a minor or an adult who is unable to sign this form)

(relationship of patient representative to patient)

(patient declined to sign acknowledgement signature of employee & date)

DESIGNATION OF PERSONAL REPRESENTATIVES

I, _____, authorize to release information about my
(name of patient)
medical care to:

(relationship)

(relationship)

I understand that I must notify Tidewater Heart Institute in writing in order to terminate this designation.

I also understand that Tidewater Heart Institute is not responsible for information that is redisclosed by
the above named individual(s).

(patient's signature)

(date)