WOODLANDS NORTH HOUSTON
HEART CENTER

HIPAA DISCLOSURE

ACKNOWLEDGEMENT OF REVIEW OF NOTICE OF PRIVACY PRACTICES

I understand that under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain rights to privacy regarding my protected health information. I have been informed of WNHHC's Notice of Privacy Practices and the complete description of the uses and disclosures of my health information.

I have reviewed this office's Notice of Privacy Practices, which explains how my medical information will be used and disclosed. I understand that I am entitled to receive a copy of this document.

Signature of Patient or Personal Representative **Date**

Name of Patient or Personal Representative

Description of Personal Representative's Authority

RELEASE OF INFORMATION AUTHORIZATION

_____ WNHHC **may not** discuss my healthcare and **may not** discuss and/or make financial arrangements with anyone.

_____ WNHHC **may** discuss my healthcare and **may** discuss and/or make financial arrangements with only the following individuals:

Name _____ **Relationship**_____

Name _____ **Relationship** _____

PREFERENCES

I prefer to be contacted in the following manner:

Phone #: _____

_____ Leave message with detailed information.

_____ Leave message with contact number only.

_____ DO NOT leave message.

Email:

_____

*(By asking to be contacted via email, you are giving permission to be web-enabled for the Patient Portal)

SIGNATURE: _____ **DATE:** _____