HEART VEIN & VASCULAR

Heart Vein & Vascular LLC

Babak Alex Vakili M.D, F.A.C.C, F.S.C.A.I

Integrative Cardiovascular Clinic

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ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES AND AUTHORIZATION TO SHARE MEDICAL INFORMATION

Date _____ Patient Name_____

By signing below, I acknowledge that I have received a copy of the HEART VEIN & VASCULAR LLC, Notice of Privacy Practices.

_____ _____

Signature of Patient or Personal Representative | Print Name of Patient or Personal Representative

_____

Description of Personal Representative's Authority

Contact Information for Personal Representative:

Address:

_____

_____

Phone Number:

_____ _____

Daytime | Evening

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I authorize HEART VEIN & VASCULAR LLC, to share my medical information with the following Persons:

Name	Relationship	Phone Number
Name	Relationship	Phone Number
Name	Relationship	Phone Number

This authorization will remain in effect from the date it is signed until I cancel it in writing.

By signing below, I acknowledge I have reviewed and understand this authorization form.

_____ _____

Patient Name and Signature | Date