Uniquely Connected. For life.℠
HERITAGE VALLEY HEALTH SYSTEM

Heritage Valley Health System Corporate Compliance Program
Receipt of Notice of Privacy Practices Acknowledge Statement

I acknowledge I have received a copy of the Heritage Valley Health Systems Notice of Privacy Practices for Protected Health Information.

Patient Name: (Please print)_____ **Date of Birth:** _____

Signature: _____ **Date:**_____

In the event of the patient's emergency condition, signature of the person receiving the notice for the patient:

_____

Consent for Messages:

_____ I prefer that all test results be given **TO ME ONLY.** If I am unavailable, please leave a message for me to return your call.

_____ I authorize the release of test results, treatment plans and messages to be discussed with: (Please list the names **of ALL** family members/friends we are permitted to speak with regarding your health.

_____ _____

_____ _____

_____ _____

_____ **Heritage Valley Medical group/ Cardiovascular and Thoracic Surgery may leave my test results or messages on my voicemail.**

Signature: _____ **Date:** _____