



Saline Heart Group, P.A.

Notice of Privacy Practices Receipt

Print Name of Patient: _____ Birthdate: _____
Month/day/year

If you would like to give us permission to discuss your personal health information with family members or friends please list them here.

1. _____
2. _____
3. _____

For Personal Representative of the Patient

(This area only applies to you if someone has power of attorney over you)

Print name of personal representative: _____

Signature of personal representative: _____

I acknowledge that I was provided with the Notice of Privacy Practices provided by Saline Heart Group.

Signature of patient: _____ Date _____

