Acknowledgement of Privacy Practices

Notice of Acknowledgement of Privacy Practices:

I acknowledge that I have received, been offered, or reviewed Gilbert Cardiology's Notice of Privacy Practices.

- Patient Signature:______________________________ Date:_______________

OR

- Personal Representative Signature:________________________ Relation:____________________
Date:_______________

If you would like any person(s) to be able to communicate with Dr. Zaki Lababidi, MD FACC FSCAI, Dr. Mohammad Hojjati MD PhD, Dr. Khaled Albasha MD FACC, Sharolyn McClurg MSN CNP, Lauren Woffinden MSN ANP or office staff about your care, please include their name below. You many add or remove any person at any time.

You may discuss my care with the following person(s):

_________________________________ _________________________________
Name **Name**

_________________________________ _________________________________
Name **Name**