



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. Khaled Albasha MD FACC, or office staff about your care, please include their name below. You may add or remove any person at any time.

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

Name

Name

Name

Name