Cardiology Associates of Savannah, LLC

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY PRACTICES

We are required to provide you with a copy of our Notice of Privacy Practices, which states how we may use and/or disclose your health information. Please sign this form to acknowledge receipt of this notice. You may refuse to sign this acknowledgement if you wish.

Signature of Patient Date

ASSIGNMENT OF BENEFITS AND RELEASE OF INFORMATION

I hereby authorize my insurance benefits to be paid directly to Cardiology Associates of Savannah and acknowledge that I am responsible for any balance not covered by those benefits. I authorize Cardiology Associates of Savannah to release information requested concerning my care to insurers paying such benefits.

Signature of Patient Date