



**Jacksonville Heart Center, P.A.**

I hereby acknowledge that I have received a copy of the Jacksonville Heart Center’s Notice of Privacy Practices.

Individual:

\_\_\_\_\_  
Printed Name

\_\_\_\_\_  
Date of Birth of Patient

\_\_\_\_\_  
Signature

\_\_\_\_\_  
Date

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**PROTECTED HEALTH INFORMATION WAIVER**

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I, \_\_\_\_\_(Patient Name), authorize Jacksonville Heart Center, PA (JHC) to use and provide medical and demographic information to the following named individuals (i.e. spouse, child, parent, care giver) if they request it on my behalf :

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

- The information to be used or disclosed may be: entire medical chart, including current and past medical history including patient demographic and billing information.
- This information can be used by the entire Jacksonville Heart Center staff as needed to coordinate and facilitate my care.

This authorization expires when so determined by the individual patient and I recognize that the protected health information (PHI) used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected.

I also hereby authorize payment directly to Jacksonville Heart Center. I understand that I am financially responsible to Jacksonville Heart Center for charges not covered by this assignment. I authorize the release of any medical information necessary to process insurance claims and coordinate my medical care.

Acknowledged and agreed to by: Patient Signature: \_\_\_\_\_

Patient Name (printed): \_\_\_\_\_ Date:\_\_\_\_\_