INTERVENTIONAL CARDIOLOGY MEDICAL GROUP, INC.
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Notice of Privacy Practices Acknowledgment Form

THE NOTICE OF PRIVACY PRACTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY, AS IT EXPLAINS:

- How this office will use and disclose your protected health information.
- Your privacy rights with regards to your protected health information.
- This office's obligations concerning the use and disclosure of your protected health information.

I acknowledge that I have received a copy of the office Notice of Privacy Practices. I further acknowledge that the office Notice of Privacy Practice is available at the front desk upon request.

_____ _____

Patient or Patient Representative Signature Date

_____

Patient or Patient Representative Printed Name