Berkeley Cardiovascular
MEDICAL GROUP

Main Office • 3300 Webster Street • Suite 702 • Oakland • California • 94609
(510) 549-4220 • FAX (510) 433-0744 • www.berkeleycardiovascular.com

Cardiac Testing Office • 3300 Webster Street • Suite 702 • Oakland • California • 94609
(510) 549-4220 • FAX (510) 433-0744

Lafayette (satellite office) 3466 Mt. Diablo Blvd. Ste. C-100 Lafayette California 94549
(510) 549-4220 FAX (510) 433-0744

John S. Edelen, M.D., F.A.C.C. Luisa Muñoz, M.D., Ph.D Samuel Wang, M.D., F.A.C.C.
Robert M. Greene, M.D., F.A.C.C. Duane D. Stephens, M.D., F.A.C.C.

Acknowledgement of Receipt of Notice of Privacy Practices

Berkeley Cardiovascular Medical Group reserves the right to modify the privacy practices outlined in the notice.

I have received a copy of the Notice of Privacy Practices for Berkeley Cardiovascular Medical Group.

_____

Name of Patient (Print or Type) Date of Birth

_____

Signature of Patient

_____

Date

_____

Signature of Patient Representative
(Required if the patient is a minor or an adult who is unable to sign this form)

_____

Relationship of Patient Representative to Patient

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO INDIVIDUALS/FAMILY MEMBERS

In accordance with Federal government privacy rules implemented through the Healthcare Portability Act of 1996 (HIPAA), in order for your physician or staff of Berkeley Cardiovascular Medical Group (the Practice) to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so. In the event of a critical episode or if you are unable to give your authorization due to the severity of your medical condition, the law stipulates that these rules may be waived.

____ I authorized the Practice to verbally and/or physically release any or all information concerning my medical care to the following individuals. For verification, the individual/individuals listed below will be prepared to state my date of birth and/or the last four digits of my social security number. If the requested information is unknown, the information requested may be denied.

____ I do not authorize the Practice to release any or all information concerning my medical care to any individual except as set forth above.

_____ _____
Name Relationship to Patient

_____ _____
Name Relationship to Patient

_____ _____
Print Patient Name Patient Date of Birth

_____
Patient Signature Date

Right to Terminate or Revoke Authorization

You may revoke or terminate this authorization by submitting a written revocation to BCVMG. You should contact the Operations Supervisor Elizabeth, at 510-549-4220 to terminate this authorization