BLUE RIDGE CARDIOLOGY & INTERNAL MEDICINE, PA

"Our" BLUE RIDGE MEDICAL GROUP

111 Comer Street, Dobson, NC 27017
905 Rockford Street, Mt. Airy, NC 27030
640 Parkwood Medical Park, Elkin, NC 28621
380 Parkwood Medical Park, Elkin, NC 28621
108 South State Street, Yadkinville, NC 27055
1909 West Park Drive, North Wilkesboro, NC 28659
665 South Main Street, Trojan Village #206, Sparta, NC 28675

Notice of Privacy Practices Acknowledgement
And
Authorization to Release Information

I understand that under the Health Insurance Portability and Accountability Act (HIPAA), I have certain rights to privacy regarding my protected health information. I acknowledge that I have received or have been given the opportunity to receive a copy of your Notice of Privacy Practices. I also understand that this practice has the right to change its Notice of Privacy Practices and that I may contact the practice at any time to obtain a current copy of the Notice of Privacy Practices.

Blue Ridge Cardiology and Internal Medicine, PA will only release medical information to the person(s) you authorize to obtain that information. Unless otherwise specified, this release includes all patient information (including Laboratory results, X-ray or imaging reports and any other medical tests).

I authorize Blue Ridge Cardiology & Internal Medicine, PA to release my medical information to the following persons: (Please list name(s) below)

FULL NAME	DATE OF BIRTH	RELATIONSHIP
FULL NAME	DATE OF BIRTH	RELATIONSHIP
FULL NAME	DATE OF BIRTH	RELATIONSHIP
FULL NAME	DATE OF BIRTH	RELATIONSHIP

We may leave appointment reminder messages or messages to return a call from us on your home or cell phone. (Please check) _____Yes _____No

THIS AUTHORIZATION BECOMES EFFECTIVE UPON YOUR SIGNATURE AND IT WILL BE YOUR RESPONSIBILITY TO NOTIFY US OF ANY CHANGES YOU WISH TO MAKE TO THIS LIST.

_____ _____
PATIENT NAME OR LEGAL GUARDIAN (PRINT) DATE

_____ _____
PATIENT SIGNATURE WITNESS NAME/SIGNATURE

Office Use Only

We have made the following attempt to obtain the patient's signature acknowledging receipt of the Notice of Privacy Practices

Date _____ **Staff Name** _____ **Method** _____

Date _____ **Staff Name** _____ **Method** _____

Revised 09.23.13