PINNACLE

CARDIOVASCULAR ASSOCIATES

AUTHORIZED PATIENT NOTIFICATION LIST

Requirement of HIPPA (Health Insurance Portability and Accountability Act)

I authorize Pinnacle Cardiovascular Associates and/or whomsoever he/she my designate as his/her professional representative/assistant to discuss any aspect of my care, to include: appointments, test, test results, surgical procedures, prescriptions, and any other pertinent information pertaining to my care with the following designated people:

Name	Relationship	Contact Number
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

This document will be part of your permanent record. In the event that any of the selected representatives that you have designated change, it will be necessary to update our records with a written notification. You will need to state who you would like to have removed from or added to the Authorization Notification List.

_____ _____

PATIENT/OTHER PERSON AUTHORIZED TO SING DATE

_____

RELATION TO ABOVE SIGNATURE

_____ _____

WITNESS SIGNATURE DATE TIME