



Gopala Krishna Rao, M.D., M.R.C.P., R.P.V.I., F.A.C.C.

Board Certified in Cardiology, Echocardiography & Vascular Interpretation

**ACKNOWLEDGEMENT OF RECEIPT OF HIPPA NOTICE
OF PRIVACY PRACTICES**

Name: _____
(PRINTED NAME)

Signature of Patient Representative: _____ Relationship: _____

COMMUNICATION REGARDING YOUR PROTECTED HEALTH INFORMATION

List person(s) whom we may release your health information to: _____

May we leave messages regarding appointment information, test results and/or treatments on your voicemail? **Yes** or **No** If yes, Phone # (____) ____ - _____

Signature: _____ Date: _____