Patient Name:_____ Patient ID:_____

Cardiovascular Consultants and Vascular Surgeons of Southern Delaware
HIPAA Questionnaire

1. Please list the name and phone number of a family member or other person, *if any*, who we may inform

   About your general medical condition, medical diagnosis, appointments and billing statement:

   □ **NONE** (***please note, if NONE is checked, we can not speak to anyone other than patient, including spouse or children)*** OR Please enter below:

   Name: _____

   Phone number: _____

   Relationship: _____

   Name: _____

   Phone number: _____

   Relationship: _____

   Name: _____

   Phone number: _____

   Relationship: _____

2. Can confidential messages be left on your home answering machine or voicemail: □ **YES** □ **NO**

3. Can confidential messages be left at your place of employment:□ **YES** □ **NO** □ **Retired** □ **Unemployed**

4. I acknowledge that I have received the "Notice of Privacy Practice" and authorize **Cardiovascular Consultants and Vascular Surgeons of Southern Delaware** to Release or obtain my private information for the purposes of my treatment, to obtain payment from a third party or conduct normal healthcare operations, per the Health Insurance Portability and Accountability Act of 1996.

_____ _____

Patient/ Legal Guardian Signature date