

Patient Name: \_\_\_\_\_

Patient ID: \_\_\_\_\_

Cardiovascular Consultants 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** 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 **CVCS D** 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