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 CVCSD 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