Faisal Bahadur, MD
Gautam Kedia, MD
Bashar Markabawi, MD, FACC

Privacy Notice Acknowledgment and Communication Consent

Patient Name: _____ DOB: _____
PLEASE PRINT NAME

Please list below the pharmacy you use including phone number, address or cross streets:
Name: _____ Phone: _____
Address/Cross Streets: _____

We must call you at times to give you what is classified as protected health information. Please let us know how we can contact you with this information and if we can leave a message.

Can we leave detailed or confidential messages on your home phone?
Yes ___ No ___ Home Number: _____

Can we leave detailed or confidential messages on your cell phone?
Yes ___ No ___ Cell Phone: _____

Can we mail test results to your home?
Yes ___ No ___

How would you like to be reminded of upcoming appointments?
Email _____ Cell/Text _____ Call/Home _____

Exclusions/Alerts (Please note any information that you do not want released to authorized individuals:
_____
_____

We must call you at times to give you what is classified as protected health information. Can we speak to anyone other than you regarding lab results, radiology results or other issues regarding your health?

NAME	RELATIONSHIP	SECRET QUESTION (i.e. Mother's maiden name, city of birth, favorite color, optional)	ANSWER
1)			
2)			

My signature below authorizes communication consent as well as acknowledges that I have received a copy of the Pioneer Cardiovascular Consultants, P.C. Notice of Privacy Practices.

_____ _____
Patient Name (please print) Date

_____ _____
Patient or Person Authorized to Sign If not patient, relationship to patient (parent, legal guardian, personal representative, etc.)