Star Cardiology Care, PC

403 Route 202 South, Suite 200, Flemington, NJ 08822

HIPAA Notice

I, _____ allow you to share my protected health information to or answer questions from the following (this includes information regarding diagnosis, treatment and medications):

Check all that apply:

____Spouse Name_____ Phone_____

____Parent(s) Name_____ Phone _____

____Child(ren) Name_____ Phone_____

Name_____ Phone_____

____Other Name_____ Phone_____

____NONE (only talk to me)

I wish to be contacted in the following manner (Check all the apply):

____ Cell Phone_____ Ok to leave detailed msg Yes___ NO___ Initial____

____ Home Phone_____ OK to leave detailed msg Yes___ No___ Initial____

____ Work Phone_____ Ok to leave detailed msg Yes___ No___ Initial____

_____

Print Name

_____ _____

Signature of Patient (or Legal Guardian) **Date**

_____I understand that I have the right to change this information at any time and I can request a copy of this form at any time. Initial_____

_____

This HIPAA form will be part of the Electronic Health Record (EHR)