

**Columbus Cardiology Associates**  
**2525 Williams Road, Columbus, GA 31909**  
**706-243-0446 Fax 706-324-5695**

**HIPPA Notice of Privacy Practices**  
**Acknowledgement of Receipt**

I, \_\_\_\_\_, \_\_\_\_\_ have been  
(Printed Patient Name) (Date of Birth)

given a copy of the Columbus Cardiology Associates brochure of Privacy Practices.

\_\_\_\_\_  
Patient Signature Date

**Authorization for Family, Friends or Advisors to Receive Information About Your Medical Condition Or  
The Status Of Your Bill.**

I authorize the following individual(s) to receive written and /or oral communications about my medical condition, care, appointments, and the status of my bill. I understand that they will need to be able to provide the last four digits of my social security number for oral communication. If they should come to pick up a prescription, or to discuss my care or the status of my bill, they will need to bring a photo id.

Authorized Individual(s) (Please print name(s))

\_\_\_\_\_  
\_\_\_\_\_  
\_\_\_\_\_

\_\_\_\_\_  
Patient Signature Date