**Cardiovascular Specialists of Frederick**

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**John A. Vitarello, M.D., F.A.C.C. Edward P. Riuli, M.D., F.A.C.C. Nirmal K. Shah, M.D., F.A.C.C. Aimee S. Park, M.D., F.A.C.C.**  **Anwar K. Malik, M.D., F.A.C.C. Sumit Duggal, M.D., F.A.C.C.**

**I\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ give Cardiovascular Specialists of Frederick**

**Dr. John A. Vitarello, Dr. Edward P. Riuli, Dr. Nirmal K. Shah, Dr. Aimee S. Park,**

**Dr. Anwar Malik, and Dr. Sumit Duggal permission to discuss the following:**

**\_\_\_\_\_\_\_\_\_\_ Diagnosis, Prognosis, and/or Treatment Information**

**\_\_\_\_\_\_\_\_\_\_ Test Results**

**\_\_\_\_\_\_\_\_\_\_ Scheduling Information**

**\_\_\_\_\_\_\_\_\_\_ Billing Information**

**\_\_\_\_\_\_\_\_\_\_ Other (Please Specify) \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**With The Following People:**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Relationship: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**I also authorize Cardiovascular Specialists to:**

**\_\_\_\_\_\_\_\_\_\_ Leave messages on my home answering machine**

**\_\_\_\_\_\_\_\_\_\_ Leave message on my work answering machine**

**\_\_\_\_\_\_\_\_\_\_ Leave message on my cell phone**

**\_\_\_\_\_\_\_\_\_\_ Leave messages with my family members or others**

**residing in my household.**

**I hereby acknowledge that I have received a copy of Cardiovascular Specialists of Frederick, LLC’s Notice of Privacy Practices. I understand that I have the right to refuse to sign this acknowledgement if I choose.**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Signature\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**NOTE: THIS FORM MUST BE FILLED OUT IN ORDER TO ENSURE THE CONFIDENTIALITY OF OUR PATIENT’S MEDICAL RECORDS.**

Revised: 9/27/19