Cardiac Associates, P.C

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEATLTH INFORMATION (PHI). CARDIAC ASOCIATES WILL NOT USE THIS INFORMATION FOR MARKETING RESEARCH OR SOLICITATION OF ANY KIND. YOUR PROTECTED INFORMATION (PHI) IS FOR THE SOLE PURPOSE OF TREATING YOU, THE PATIENT.

PLEASE COMPLETE THE FOLLOWING INFORMATION:

Name:____

Address:____

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Phone: Home: ____________________ ***Cell:*** ____________________

Work____________________ ***Fax:***____________________

Date Of birth:____________________ ***SS #:***____________________

I AUTHORIZE CARDIAC ASSOCIATES TO RELEASE MY MEDICAL RECORDS, LAB AND ECHO REPORTS, AND/OR BILLING RECORDS, FOR THE PURPOSE OF TREATMENT, PAYMENT, AND HEALTHCARE OPERATIONS (TPO) ONLY. I UNDERSTAND CARDIAC ASSOCIATES WILL NOT RELEASE ANY OTHER INFORMATION WITHOUT FIRST SEEKING AUTHORIZATION FROM ME.

IF YOU DO NOT WANT YOUR TEST RESULTS, BILLING INFORMATION OR ANY OTHER CORRESPONDENCE FROM CARDIAC ASSOCIATES TO BE SENT TO YOUR HOME ADDRESS, WHERE WOULD YOU LIKE IT SENT?

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I AUTHORIZE CARDIAC ASSOCIATES TO: (PLEASE CHECK ALL APPROPRIATE RESPONSES):

_______Send my billing Info to my home address

_______Be contacted by phone to confirm appointments

_______FAX my test results or other info to my fax number: ____________________

_______ Leave a voicemail message on my answering machine confirming appointments.

_______ Leave message at the above phone number to give updates on medication and/or treatment

_______To discuss TPO with the following designated person or persons: ____________________

I UNDERSTAND THAT THIS AUTHORIZATION WILL BE EFFECTIVE FOR ONE YEAR FROM THE DATE SIGNED AND THAT AT ANY TIME I HAVE THE RIGHT TO REVOKE ANY AUTHORIZATION.

I UNDERSTAND THAT THIS AUTHORIZATION IS VOLUNTARY AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION. MY REFUSAL TO SIGN WILL NOT AFFECT MY ABILITY TO OBTAIN TREATMENT, RECEIVE PAYMENT OR ELIGIBILITY FOR BENEFITS UNLESS ALLOWED BY LAW.

Signature of Patient or Rep.:____________________ Date:____________________

If Rep., Relation to Patient:____________________

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CARDIAC ASSOCIATES, P.C.

Privacy Notice

THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

We are committed to providing you with high quality care and to forming a relationship with you that is built on trust. We understand that information about you is private and we are committed to protecting this information. We protect your privacy and confidentiality rights by creating and putting into practice policies and procedures that allow access to your personal information only for legitimate reasons.

This notice describes how your health information may be used and disclosed by us, your rights with regards to your health information, and our duties to protect such information. It applies to all records of your care that we maintain. Whether this information is stored in writing, on computer, or other means, we will keep this information in a safe and secure way that protects your privacy and confidentiality.

USES AND DISCLOSURES OF YOUR HEALTH INFORMATION

This section describes how we use and disclose your health information. Below, we have listed the types of uses and disclosures that we may make. Any use or disclosure that is not listed below will only be made with your written authorization.

Without Your Authorization.

Your health information may be used and disclosed by us for the following purposes without your legal permission. However, prior to making such disclosure that is not listed below will only be made with your written authorization.

Treatment, Payment and Business Purpose: We use and disclose your health information to enable us to provide treatment to you, obtain payment for your care, and manage and administer our practice. For instance, we may use and disclose your health information to your insurer, HMO, or other third party payer to obtain for the services that we provide you. As another example, in consulting with a specialist regarding your health care treatment, we use and disclose your information. As a further illustration, we may use and disclose your health information to review the adequacy and quality of the care that you receive. As another example of managing our practice, we may use and disclose your information to create de-identified information to enable us to study our treatment patterns and the care that we provide.

Individuals Involved in Your Care or Payment or Notifications: We may disclose your information to your family members or friends who are involved in your care or who assist you in paying for your care. If we need to notify family and/or friends of your medical condition and/or location, we may also disclose your information. This notification may be via a disaster relief effort, such as the American Red Cross.

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