COLLINS CARDIOLOGY

PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for **Collins Cardiology** to use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operations. The Notice of Privacy Practices provided by **Collins Cardiology** describes such uses and disclosures more completely and is continually posted on the wall in the waiting room at **Collins Cardiology**.

I have the right to review the Notice of Privacy Practices prior to signing this consent. **Collins Cardiology** reserves the right to revise its Notice of Privacy Practices at any time. A revised Notice of Privacy Practices may be obtained by forwarding a written request to **Collins Cardiology**.

With this consent, **Collins Cardiology** may call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory test results, among others.

With this consent, **Collins Cardiology** may mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements."

With this consent, **Collins Cardiology** may e-mail to my home or other alternative location any items that assist the practice in carrying out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS, such as appointment reminder cards and patient statements. I have the right to request that **Collins Cardiology** restrict how it uses or discloses my PHI to carry out TREATMENT, PAYMENT, AND HEALTH CARE OPERATIONS. **Collins Cardiology** is not required to agree to my requested restrictions, but if it does, it is bound by this agreement.

By signing this form, I am consenting to allow **Collins Cardiology** to use and disclose my PHI to carry out treatment, payment, and health care operations.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, or later revoke it, **Collins Cardiology** may decline to provide treatment to me.

Print Patient Name: _____ Date of Birth: _____

Print Name of Legal Guardian, if applicable: _____ Relation: _____

Signature of Patient or Legal Guardian: _____ Date: _____

Please list any authorized persons to receive medical information on your behalf:

1. Name: _____ Relationship to patient: _____

2. Name: _____ Relationship to patient: _____

3. Name: _____ Relationship to patient: _____