

Northside Cardiology P.C.
PATIENT CONSENT FOR USE AND DISCLOSURE
OF PROTECTED HEALTH INFORMATION

Northside Cardiology P.C. is committed to protecting your health information. We will not release confidential medical information regarding your care to unauthorized persons. You have the right to request us to restrict use or disclosure of your health information, including information for treatment, payment or health care operations. Northside Cardiology P.C. has no obligation to agree to the request, but will review each request carefully.

NAME: _____ **MR#** _____

SS# _____ **Date of Birth** _____ **Date of Request** _____

1. Yes No Northside Cardiology P.C. may call my home or other alternative location (i.e. cell phone, voicemail, pager) and leave a message on voicemail or in person in reference to any items that assist Northside Cardiology P.C. in carrying out treatment, payment and health care operations, including appointment reminders, insurance items and any calls pertaining to my clinical care, including laboratory results, among others. If an alternative location/number is requested, please list:

2. Yes No Northside Cardiology P.C. may mail to my home or alternative location any items that assist Northside Cardiology P.C. in carrying out treatment, payment and health care operations,, such as appointment reminders cards and patient statements, If an alternative location is requested, please list:

3. Yes No Northside Cardiology P.C. may e-mail to my home or other alternative location any items that assist Northside Cardiology P.C. in carrying out treatment, payment and health care operations, such as appointment reminders and patient statements. My e-mail address is:

4. Yes No Type of health information to be restricted or limited: (Please check all that apply)

- | | | |
|--|---|--|
| <input type="radio"/> Spouse's name | <input type="radio"/> Home Phone | <input type="radio"/> Home Address |
| <input type="radio"/> Name of Employer | <input type="radio"/> Occupation | <input type="radio"/> Office Address |
| <input type="radio"/> Office Phone | <input type="radio"/> Spouse's Office Phone | <input type="radio"/> Medical History |
| <input type="radio"/> Treatment Notes | <input type="radio"/> Physician Notes | <input type="radio"/> Prescription Information |
| <input type="radio"/> Other _____ | | |

5. List the names of individuals you would prefer us not to leave messages or communicate with:

6. Designated method of contacting patient/resident/client:

Communications with the patient/resident/client named above should be directed to:

Mailing Name

Street Address

City

State

Zip

Telephone Number

_____ Spouse _____ Children _____ Other *Please specify relationship _____

I understand that Northside Cardiology P.C. is a health care provider and may share my information for treatment, payment and health care operations. I hereby give my consent for Northside Cardiology P.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment and healthcare operations (TPO).

I have the right to review the Notice of Privacy Practices prior to signing this consent. Northside Cardiology P.C. reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to Northside Cardiology P.C. Privacy Officer at 5670 Peachtree Dunwoody Road, Suite 880, Atlanta, GA 30342.

By signing this form, I am consenting to Northside Cardiology P.C.'s use and disclosure of my PHI to carry out TPO.

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, Northside Cardiology P.C. may decline to provide treatment to me.

My signature below constitutes my acknowledgement that I have been provided with a copy of the Notice of Privacy Practices.

If any person is physically unable to provide a signature or signs with a mark, print his/her name of the appropriate line below and record the signatures of two responsible persons who witness that such person understands the nature of this acknowledgement.

If patient is not capable of acknowledging the notice because of age or medical condition, complete the following:

Patient is a minor (____ years of age) or Patient is unable to acknowledge because _____

Signature of Patient/ Legal Guardian/ Relative

Date

Legal Guardian/ Relative Relationship

Witness

Date

Witness

Date

For Northside Cardiology P.C. use only: Version Given: _____

Patient did not sign due to: _____

<p>Alternative Arrangements for Payment</p> <p>Payment for services provided to the patient will be made as follows and has been discussed with Northside Cardiology P.C. Business Office (describe payment arrangement):</p> <p>_____</p> <p>_____</p> <p>_____</p>
