

COMPREHENSIVE CARDIOLOGY CONSULTANTS

PATIENT AUTHORIZATION FORM

Our Notice of Privacy Practices provides information about how we may use and disclose Protected Health Information about you. The Notice describes how medical information about you may be used and disclosed as well as how you may get access to this information. The Notice contains a Patient Rights section describing your rights under the law. You have the right to review our Notice before signing this Authorization. The terms of our Notice may change. If we change our Notice, you may obtain a revised copy by contacting our office.

You have the right to request that we restrict how Protected Health Information about you is used or disclosed for treatment, payment or health care operations. We are not required to agree to this restriction, but if we do, we shall honor that agreement.

By signing this form, you authorize our use and disclosure of Protected Health Information about you for treatment, payment, and health care operations. You have the right to revoke this Authorization, in writing, signed by you. Such a revocation shall not affect any disclosures we have already made in reliance on your prior Authorization. The Practice provides this form to comply with the Health Insurance Portability and Accountability Act of 1996 (HIPAA).

The patient understands that:

- Protected Health Information may be disclosed or used for treatment, payment or health care operations.
- Comprehensive Cardiology Consultants has a Notice of Privacy Practices and the patient has the opportunity to review this Notice.
- The Practice reserves the right to change the Notice of Privacy Policies.
- The patient reserves the right to restrict the use of their information but the Practice does not have to agree to these restrictions.
- The patient may revoke this Authorization in writing at any time and all future disclosures will then cease.

HEALTH INFORMATION DISCLOSURE AUTHORIZATION: Please circle those family members to whom our Physicians and Staff may disclose / discuss your medical records / test results:

NONE SPOUSE CHILDREN PARENTS OTHER: _____

Please list names here: _____

MAY WE LEAVE A VOICE MAIL: (circle one) YES NO Phone Number _____

Patient Name: (please print) _____

Signature: _____ Date: _____

Relationship to Patient (if other than patient): _____

COMPREHENSIVE CARDIOLOGY CONSULTANTS

PATIENT INFORMATION FORM

PATIENT NAME: _____ **DOB:** _____

STREET _____ **APT#:** _____

CITY _____ **STATE** _____ **ZIP** _____

SEX: M _____ F _____ **RACE:** _____ **ETHNICITY:** _____ **MARITAL STATUS:** _____

S.S.#: _____ **E-MAIL ADDRESS:** _____

HOME PHONE #: _____ **CELL PHONE #:** _____

OCCUPATION: _____ **WORK PHONE #:** _____

EMPLOYER: _____

SPOUSE/GUARDIAN NAME: _____ **DOB:** _____ **S.S.#:** _____

NAME OF CONTACT PERSON OTHER THAN SPOUSE: _____

RELATIONSHIP: _____ **HOME PHONE #:** _____ **WORK #:** _____

REFERRED BY: _____

FAMILY/PRIMARY CARE PHYSICIAN (PCP): _____

PRIMARY INSURANCE: _____

POLICY HOLDER'S NAME: _____ **DOB:** _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER (circle one): SELF SPOUSE CHILD OTHER

SECONDARY INSURANCE: _____

POLICY HOLDER'S NAME: _____ **DOB:** _____

PATIENT'S RELATIONSHIP TO POLICY HOLDER (circle one): SELF SPOUSE CHILD OTHER

MEDICAL BENEFITS PAYMENT AUTHORIZATION: I authorize payment of medical benefits to Comprehensive Cardiology Consultants for the amount due on any pending claim for services rendered. YES _____ NO _____

SIGNATURE: _____ **DATE:** _____