Advanced Cardiovascular Consultants, Inc.
Privacy Consent- For the Use and Disclosure of Protected Health Information

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Due to Federal Regulations we need to know with whom we can release any of your medical information.

Who may we speak to about your medical concerns? Please list names of all parties.

1. **_____ relationship_____**
2. **_____ relationship_____**
3. **_____ relationship_____**

Physicians: 1._____2._____3._____

May we leave a message at your home with a person or on a machine? Yes () No ()

This consent is required by the Health Insurance Portability and Accountability Act of 1996 to inform you of your rights for privacy with respect to your health care information.

I hereby give my consent to Advanced Cardiovascular Consultants, Inc. to use and disclose my protected health information for the purposes of treatment, payment and operations of my health care and this practice.

Consent for treatment: I, with my signature, authorize Advanced Cardiovascular Consultants, Inc., and any employee working under the direction of the physician, to provide medical care for me, or to this patient for which I am the legal guardian. This medical care may include cardiac management and the conditions related to it. This may include (but not limited to) evaluation, medical management, procedures, diagnostic testing, therapeutic care, counseling, the prescribing of drugs or other services required for your care. This consent includes contact and discussion with other health care professionals, such as primary care or specialists for your care and treatment.

Consent for release of information for payment and operations: I also authorize this practice to furnish information to the identified insurance carrier (s) for any and all payment activities. I further consent to the use for any practice operational needs as identified in the practice privacy notice. My medical record may include information about skin and related health care, drug or substance abuse and HIV or AIDS, or other related diagnosis and conditions. This may include photographs for prior authorization in some cases.

Consent related to the Privacy Notice: I have had a chance to review the Practice Privacy Notice as part of this registration process. I understand that the terms of the Privacy Notice may change and I may obtain these revised notices by contacting the practice by phone or in writing. I understand I have the right to request how my protected health information (PHI) has been disclosed. I also have the right to restrict how this information is disclosed, but this practice is not required to agree to my restrictions. If it does agree to my restrictions on PHI use, it is bound by that agreement. **Release of information to BWC is part of your claim process and cannot be restricted or limited.**

I understand that this practice may refuse me services if I refuse to sign this consent. I may revoke this consent at any time, but the practice may refuse further services at that time. If I revoke this consent, the revocation does not take affect until the practice receives it.

(X) Patient\Guardian Signature: _____ Date: _____

Name printed: _____If not the patient, relationship: _____

Consent for assignment of benefits: I consent to assign all payments for these services to this practice. I understand that I am responsible for all co-payments, amounts applied to deductibles and other amounts that may be deemed my responsibility by the payment sources, as required by my contract with my insurance plan and state regulation. I further understand that my contract with my insurance entity may or may not cover some services. It is my responsibility to obtain information from my health plan about service coverage. I also understand that some services may not be covered and considered self pay by my insurance coverage (example: Botox treatment for pain are often not covered). If I seek care outside of the contract, I am aware that I may be responsible for all charges that are incurred.

(X) Patient\Guardian Signature: _____ Date: _____