Atlantic Cardiology

PRIVACY CONSENT FORM REQUIRED BY FEDERAL HIPAA LAW #101-191
For Use or Disclosure of Private Health Information

- Trust is the foundation of a doctor/patient relationship.
- The information that you provide us is kept in the strictest of confidence.
- While protecting your privacy is extremely important to us, there may be certain situations in which we may have to use or disclose your health care information:

1. It may be necessary to use or disclose your private health information to another health care provider or hospital if it is necessary to refer you to them for the diagnosis, assessment, or treatment of your health information.
2. It may be necessary to use or disclose your private health information and billing records to another party if they are responsible for the payment of your services.
3. It may be necessary to use or disclose your private health information within our practice for quality control and operational purposes.

Patient Rights Under HIPAA Law #101-191

1. You have the right to request that we do not disclose your private health information to specific individuals, companies, or organizations under the following circumstances:
    a. All requests must be in writing
    b. By law, we are not required to agree with your restrictions, HOWEVER,
    c. If we agree with your restrictions, the restrictions are binding on us.
2. You have the right to REVOKE your authorization under these certain conditions:
    a. It must be in writing
    b. The request will not be honored if we have already released your private health information before we received your request to revoke the authorization.
    c. If you were required to give your authorization as a condition of obtaining insurance, the insurance company may have the right to your private health insurance should they decide to contest any of your claims.

Medical Information Release: (Please answer "yes" or "no" for the following):

Family Doctor: Yes No Name: _____

Spouse: Yes No Name: _____

Parents: Yes No Names: _____
(If patient is over 18)

Other: Yes No Name(s): _____

May we leave a message on the phone numbers listed? Yes No

PLEASE INDICATE ANY PERSON YOU WOULD LIKE US TO SHARE YOUR HEALTHCARE INFORMATION WITH, *THROUGH PATIENT PORTAL*:

NAME: _____ **EMAIL:** _____

I have read your policy and agree to its terms. I also acknowledge that once I sign this consent form, I will receive a copy of this completed form for my own records. I have been provided the company's Notice of Privacy Practices.

_____ _____
Printed Patient Name Printed Authorized Provider Name

_____ _____
Signature of Patient AND Date Signature of Authorized Provider AND Date

IF PERSON IS NOT SAID PATIENT, PRINT AND SIGN NAME AND RELATIONSHIP TO PATIENT:

_____ Relationship: _____ DATE: _____