Southeastern Cardiology Consultants, PC

HIPAA: Health Insurance Portability and Accountability Act

Consent for use or disclosure of protected health information (PHI) for payment, treatment and health care operations

By signing below, you hereby consent for Southeastern Cardiology Consultants, PC to use or disclose information about yourself (or another person for who you have the authority to sign) that is protected under federal law, for the sole purposes of treatment, payment, and health care operations. You may refuse to sign this consent form.

You should read the Notice of Privacy Practice for PHI available to you in the brochure folders located in our waiting room and at the front desk before signing this consent. The terms of the Notice may change from time to time, and you may always get a revised copy of it by asking the front desk or the Privacy Officer of Southeastern Cardiology Consultants, PC.

You have the right to request that Southeastern Cardiology Consultants, PC restrict how PHI is used or disclosed to carry out treatment, payment, or healthcare operations. Southeastern Cardiology Consultants, PC is not required to agree to requested restrictions. However, if Southeastern Cardiology Consultants, PC agrees to your requested restrictions, the restriction is binding on it.

Information about you is protected under federal law, and you have the right to revoke this consent, unless we have taken action in reliance on your authorization (as determined by our Privacy Officer). By signing below, you recognize on your authorization (as determined by our Privacy Officer). By signing below, you recognize that the PHI used or disclosed to this consent may be subject to re-disclosure by the recipient and may no longer be protected under federal law.

Southeastern Cardiology Consultants, PC may communicate with the following individuals regarding my condition or course of treatment:

_____ _____

_____ _____

_____ _____

_____ _____

You may communicate confidential information to me, including invoices for services, to the following address and/or phone numbers:

_____

_____

Individual Signature: Date:

_____ _____

As a personal representative, I have authority to act for the individual because I am the individual's (Please give your name and relationship to the patient):

_____ _____

Name Relationship