

Consent for Release of Protected Health Information

I, _____, _____, _____
(Patient Name) (Date of birth) (Social Security Number)

Consent to the release of protected health information that is required to carry out treatment, or for payment of healthcare operations on my behalf.

I have received a copy of the Notice of Privacy Practices and am aware of the following:

- I have the right to place restrictions on the way my protected health information is used or disclosed.
- I understand that once Cardiac Solutions agrees to my restrictions, it must comply with those restrictions.
- I have a right to revoke my consent for the use and disclosure of my protected health information at any time. I understand that, if I choose to revoke my consent, I must submit a written statement that is signed by me.
- I understand that Cardiac Solutions must immediately comply with my request to revoke consent, except to the extent that it has already taken some action that was based on my original consent.
- Cardiac Solutions has reserved the right to change from time to time our privacy practices that are described in the Notice of Privacy Practices. Whenever we change our practices, we will modify the Notice accordingly; and we will inform you, placing the amendment date at the bottom of the posted Notice.

I understand that on occasion Cardiac Solutions may need to contact me concerning health matters. On these occasions I give permission to:

Speak to another authorized party.....YES [] NO []

Name of Authorized Party _____ Date of Birth _____

Name of Authorized Party _____ Date of Birth _____

Name of Authorized Party _____ Date of Birth _____

Name of Authorized Party _____ Date of Birth _____

_____ _____
Patient Name (Print) Signature Date

For office use only:

Responsible Physician: JC VP GJ CM MR JS PP PQ FK MKR ANS RG

02/04/11