EAST BAY CARDIOVASCULAR
AND THORACIC ASSOCIATES

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

(Must be updated if patient has **NOT** been seen in 2 year period)

MEDICAL INFORMATION CAN BE DISCUSSED WITH:

☐ Patient Only ☐ Other (print name(s)): _____

Relationship to patient: _____ Telephone: (_____) _____-_____

FINANCIAL INFORMATION CAN BE RELEASED TO:

☐ Patient Only ☐ Other (print name(s)): _____

Relationship to patient: _____ Telephone: (_____) _____-_____

DETAILED MESSAGES REGARDING MY MEDICAL CARE CAN BE LEFT ON MY ANSWERING MACHINE AND/OR VOICEMAIL SERVICE:

☐YES ☐NO

CONSENT TO USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION:

My protected health information may be used by East Bay Cardiovascular & Thoracic Associates or disclosed to others for the purpose of treatment, obtaining payment or reporting the day-to-day health care operations of the practice. I have received a copy of East Bay Cardiovascular & Thoracic Associates' "Notice of Privacy Practices" and agree that the center may use my information in said policy. I understand that I may request a restriction on the use or disclosure of my protected health information. East Bay Cardiovascular & Thoracic Associates may or may not agree to restrict the use or disclosure of my protected health information. If the Center agrees to my request, the restriction will be binding on the Center. Use or disclosure of protected health information in violation of an agreed upon restriction will be a violation of the federal privacy standards. I may revoke this consent to the use and disclosure of my protected health information. I must revoke this consent in writing. Any disclosure that has already occurred prior to the date on which my revocation of consent is received will not be affected. The Center reserves the right to modify the privacy practices outlined in the notice.

OUR PROMISE OF PRIVACY AND CONSENT TO PATIENT RECORDS:

Our office is fully committed to compliance with HIPPA guidelines by:

Providing appropriate security for our patient's records.
Protecting the privacy of our patients and their medical records.
Providing our patients with proper access to their medical records.
Appropriately maintaining our patient information and billing process with national standards.

If you ever have questions or concerns regarding our services or charges related to your care, we encourage you to call and ask for our Compliance Officer.

By signing below, you acknowledge your consent for items listed above and your understanding of these guidelines.

Patient Printed Name: _____

Patient/Agent Signature: _____ **Date: _____**

Witness Signature: _____