THE USE AND DISCLOSURE OF HEALTH INFORMATION

I, ______________________, understand that as part of my health care, ***Cardiology Partners, P.L.,*** originates and maintains paper / electronic records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care of treatment. I also understand that ***Cardiology Partners, P.L.,*** uses a computerized medical records system and that infrequent typos may occur. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communication among the many health professionals who contribute to my care
- A source of information for applying my diagnosis and surgical information to my bill
- A means through which a third party payer can verify that services billed were actually provided
- A tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals

I understand and have been provided with Notice of Information Practices that provides a more complete description of information uses and disclosures. I understand that I have the following right and privileges:

- The right to review this notice prior to signing the consent
- The right to object to the use of my health information for directory purposes
- The right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations.

I understand that ***Cardiology Partners, P.L.,*** is not required to agree to the restrictions requested. I acknowledge that I may revoke this consent in writing, except to the extent the organization has already taken action in reliance thereon. I also understand that by refusing to sign or revoking this consent, this organization may refuse to treat me as permitted by Section 164.506 of the Code of Federal Regulations.

I further understand that ***Cardiology Partners, P.L.,*** reserves the right to change their notice and practices prior to implementation, in accordance with Section 164.520 of the code of Federal Regulations. Should ***Cardiology Partners, P.L.,*** change their notice, they will send a copy of any revised notice to the address I have provided (U.S. Mail or, if agreed, by E-mail).

I understand that as part of this organization's treatment, payment, or healthcare operations, it may become necessary to disclose my protected health information to another entity, and I consent to such disclosures for these permitted uses, including disclosures via fax.

I fully understand and accept the terms of this consent.

Patient / Guardian Signature: ______________________________ Date: ____________

□ I decline the terms of this consent

Office use only: □ Consent Received by: ___________ □ Consent scanned on: ____________
□ Consent refused by patient, and treatment refused as permitted