California Vascular Care
An affiliate of EAST BAY CARDIOVASCULAR & THORACIC ASSOCIATES

6 Year Consent Form

(Must be updated if patient has not been seen in a two-year period)

MEDICAL INFORMATION CAN BE DISCUSSED WITH:

Patient Only _____

Other (Print Names): _____

Relationship to Patient: _____ Telephone: _____

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

YES_____ NO_____

FINANCIAL INFORMATION CAN BE RELEASED TO:

Patient Only _____

Other (Print Names): _____

Relationship to Patient: _____ Telephone: _____

RELEASE OF MEDICAL RECORDS:

I authorize California Vascular Care to obtain any of my previous medical records pertaining to my care**.**

Patient Initials: _____

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.

PRINTED NAME: _____

SIGNATURE: _____ **DATE:** _____