

HEALTH INSURANCE PORTABILITY AND ACCOUNTABILITY ACT (HIPAA) CONSENT FORM

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

MEDICAL INFORMAT	TION CAN BE DISCUSSED V	VITH:			
☐ Patient Only	☐ Other (print name(s)):				
Relationship to patient:		7	Telephone: ()		
	ATION CAN BE RELEASED ☐ Other (print name(s)):				
	ip to patient:) -	
Kelationsh	p to patient.	TCI	срионе. <u>(</u>		
DETAILED MESSAGE MACHINE AND/OR VO □YES □N		AL CARE CAN BE	LEFT ON M	Y ANSW	ERING
for the purpose of treatme have received a copy of E the center may use my inf of my protected health inf the use or disclosure of m binding on the Center. Us be a violation of the feder health information. I must	mation may be used by East Bay nt, obtaining payment or reporting ast Bay Cardiovascular & Thoratormation in said policy. I understormation. East Bay Cardiovascular by protected health information. It is or disclosure of protected health all privacy standards. I may revolute revoke this consent in writing. A consent is received will not be afformation.	ng the day-to-day here icic Associates' "Not stand that I may requilar & Thoracic Associates the Center agrees to the information in violet this consent to the Any disclosure that he	alth care operatice of Privacy est a restriction ciates may or roo my request, thation of an age use and disclosus already occ	Practices" n on the us may not ag the restrict reed upon osure of m curred prior	e practice. I and agree that se or disclosure gree to restrict ion will be restriction will y protected r to the date on
	IVACY AND CONSENT TO It ted to compliance with HIPPA §		DS:		
Protecting the priv Providing our pati	iate security for our patient's recacy of our patients and their medents with proper access to their rentaining our patient information	dical records. nedical records.	with national s	tandards.	
If you ever have questions and ask for our Complian	s or concerns regarding our service Officer.	ces or charges relate	d to your care,	we encou	rage you to call
By signing below, you ac	knowledge your consent for item	ns listed above and yo	our understand	ling of thes	se guidelines.
Patient Printed N	ame:				
Patient/Agent Sig	nature:		Date:		_
Witness Signatur	e:				