Patient Consent for Use and the Disclosure of Protected Health Information

With my consent, Cardiovascular Associates, (MNCA) may use and disclose protected health information (PHI) about me to carry out treatment, payment and health care operation. (TPO) Please refer to Cardiovascular Associates, Notice of Privacy Practices of a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. Cardiovascular Associates reserves the right to revise its Notice of Privacy Practices at any time. A revised notice may be obtained by forwarding a written request to Cardiovascular Associates,

With my consent, I authorize MNCA to release any medical information including procedures, history, progress and exam reports, lab results, EKG reports or any other medical information to the following person(s) listed below in relation to my medical care. _____(initial)

_____

_____

With my consent, MNCA may request from any Hospital, Medical Center, Private Doctor's Office or Testing Center my health records, progress notes, test reports or lab results for my continued medical treatment. _____(initial)

With my consent, MNCA may call my home or other designated location and leave a message on voice mail in reference to any item(s) that may assist the practice in carrying out TPO. Items include but are not limited to: appointment reminders, insurance items, test results, lab results or any reference to my clinical care. _____(initial)

With my consent, MNCA may fax my home or other designated location any information I, or any of my designated representatives have requested._____ (initial)

With my consent, MNCA may mail to my home or any other designated location any item(s) that assist the practice in carrying out TPO, such as appointment reminder cards or patient statements. _____ (initial)

By signing this form, I am consenting to Cardiovascular Associates, use and disclosure of my PHI to carry out TPO.

I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent. If I do not sign this consent, Cardiovascular Associates may decline to provide treatment to me.

_____

Signature of Patient or Legal Guardian (if patient is a minor) Date

_____

Patient's Printed Name Legal Guardian's Printed Name