CAROLINA CARDIOLOGY ASSOCIATES

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PATIENT CONSENT FORM

You may give Carolina Cardiology Associates written authorization to disclose you protected health information to anyone that you designate, such as a family member or personal representative. If you wish to authorize a person to receive your protected health information, please complete the form below. You may also use this form to give us consent to leave detailed information (results of labs, xray, prescription refills, etc.) on your home answering machine, voice mail or cell phone.

Patient Name: _____ Date of Birth:_____

At my request, I authorize Carolina Cardiology Associates to disclose my protected health information to:

Name:_____Phone #: _____

Name:_____Phone #: _____

Name:_____Phone #: _____

At my request, I also authorize Carolina Cardiology Associates to communicate my protected health information to me via the following methods:

☐ Leave detailed message on my home answering machine (phone #: _____)

☐ Leave detailed message on my cell phone voice mail (phone #: _____)

I have been given a copy of the Notice of Privacy Practices. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time to obtain a current copy of the Notice of Privacy Practices.

I understand that I may cancel this authorization at any time in writing by notifying Carolina Cardiology Associates. However, if I cancel this authorization, I also understand that the cancelation will not affect any action Carolina Cardiology Associates took in reliance on this authorization before receipt of written notice of cancellation.

Authorized signature: _____ Date:_____