Georgia Heart Physicians, LLC

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PATIENT CONSENT FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

I hereby give my consent for Georgia Heart Physicians, L.L.C. to use and disclose protected health information (PHI) about me to carry out treatment, payment, and healthcare operations (TPO). I have reviewed the Notice of Privacy Practices prior to signing this consent. Georgia Heart Physicians, L.L.C. reserves the right to revise its Notice of Privacy Practices at any time.

WITH THIS CONSENT, GEORIGA HEART PHYSICIANS, L.L.C. MAY:

1. Call my home or other alternative location and leave a message on voice mail or in person in reference to any items that assist the practice in carrying out TPO, such as appointment reminders, insurance items, and clinical care among others.
2. Allow my legal guardian, parent, or caretaker to be present in the examination room during my treatment.
3. If unable to pick up my written prescriptions, medication samples, letters or copies of test results, among other items.
4. I give permission for my spouse legal guardian, parent, or caretaker to discuss my billing account.
5. I have received a copy of Georgia Heart Physicians, L.L.C. Notice of Privacy Practice.

I have the right to request that Georgia Heart Physicians, L.L.C. restrict how it uses or discloses my PHI to carry out TPO. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I reserve the right to revoke my consent in writing at any time.

_____ _____

Signature of Patient/Legal Guardian | Signature Date

_____

Please Print Patients Legal Name