



Acct # \_\_\_\_\_

### **Patient Consent Form**

By signing this form, you are granting consent to Capital Cardiovascular Specialists, PLLC to use and disclose your protected health information for the purposes of treatments, payment and health care operations. Our Notice of Privacy Practice (*Federal Register*, 45 CFR 164.520) provides more detailed information about how we may use and disclose protected health information about you.

You have the right to review our Notice of Privacy Practices before you sign this consent. Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a revised copy by accessing our web site contacting our organization at 1-512-445-5998.

You have a right to request that we restrict how we use and disclose your protected health information for the purpose of treatment, payment or health care operations. We are not required to agree to this restriction. However, if we decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent, in writing, except where we have already made disclosures in reliance on your prior consent.

Signature of Patient or Legal Representative: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Date: \_\_\_\_\_

### **Acknowledgement of Receipt of “Patient Notice of Privacy Rights” Summary Notice “THIS NOTICE DESCRIBES HOW MEDICAL INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION.”**

As our patient, under HIPAA, the new federal privacy act, you have specific privacy rights. This notice is provided in 2 pages. This 1<sup>st</sup> page summarizes how we handle your health information, and contains the acknowledgement of receipt that we are required by law to attempt to obtain. The 2<sup>nd</sup> page contains the details about our privacy policies and procedures.

We are required to have a notice available for our patients detailing how medical information about you may be used and disclosed and how you can get access to this information. You have a right to review our notice before signing this acknowledgement. A copy of our “Patient Notice of Privacy Rights” is posted in our waiting room and is made available from the receptionist to each patient. The terms of our notice may change. Any change in our notice will be posted in our waiting rooms. This is a summary notice of your rights.

A summary of your rights includes your right to:

- a. restrict the use and disclosure of health care information (but your doctor is not required to grant this type of request)
- b. receive confidential communications in an alternate form or location
- c. inspect, copy, and amend protected health information (you may be billed for the cost of copying)
- d. know about any unauthorized disclosure of protected health information
- e. have a copy of our patient privacy notice

You must be given a copy of the “PATIENT NOTICE OF PRIVACY RIGHTS with REGARD TO HEALTH CARE INFORMATION”, From Our Receptionist.

Signature Acknowledgement:

I acknowledge the receipt of a copy of the “Notice of Privacy Practices” from Capital Cardiovascular Specialists, PLLC.

Signature of Patient or Legal Representative: \_\_\_\_\_

Please Print Name: \_\_\_\_\_ Date: \_\_\_\_\_