SCOTTSDALE CARDIOVASCULAR CENTER PC PATIENT CONSENT FOR PROTECTED HEALTH INFO
PATIENT DISCLOSURE FORM

I authorize and agree that Scottsdale Cardiovascular Center PC (SCC) may disclose my protected health information to the following persons (family, friends), each of whom is directly involved in my care:

1_____ 2_____

3_____ 4_____

E-mail address may be used:_____

I ACKNOWLEDGE and agree that Scottsdale Cardiovascular Center PC (SCC) may disclose my protected health information to the persons set forth, or to the email address set forth, in this form unless and until I object to such disclosures, which must be provided in writing to Scottsdale Cardiovascular Center PC (SCC). I acknowledge that Scottsdale Cardiovascular Center (SCC) may provide my health information to my other treating physicians. I further acknowledge and agree that I am not required to complete or execute this form.

DATE:_____ _____
Signature of Patient or Legal Guardian

_____
Print name of Patient Date of Birth

PLEASE CHECK APPLICABLE STATEMENTS:

___ With this consent, I authorize SCC to call my home or alternative location, leave a message on voice mail, or contact me with reference to any items that assist SCC in carrying out functions of the medical practice including, but not limited to, appointment reminders, insurance queries, lab test results, prescription information and other types of examinations.

___ Alternate location and phone number:_____

___ With this consent, I authorize SCC to mail to my home or alternate location designated above any items that assists SCC in carrying out functions of the medical practice including, but not limited to,
Appointment reminders, patient statements, written test results and treatment instructions.

___ Alternate location and phone number_____

___ With consent, I authorize SCC to transmit via a secure, encrypted internet connection, any items which assists SCC in carrying out functions of the medical practice, including but not limited to, patient care, test results, prescriptions, inter-office communication.

___ With consent, I authorize SCC to contact me via e-mail. My e-mail address _____ _____. I understand it is my responsibility to inform SCC in writing of any changes to this information.

FINALLY, I UNDERSTAND, that I have the right to request, in writing, that SCC limit or restrict its use or disclosure of my protected health information. I further understand that SCC may refuse to accept this request for limitation or restriction, if, in its professional opinion, it would compromise or limit its ability to carry out treatment, obtain payment, or perform healthcare operations. In the event SCC agrees with and accepts a restriction request regarding my protected health information, it shall be required to abide by the agreement.

BY SIGNING THIS CONSENT FORM, I consent to the above. I understand I may revoke this consent in writing at any time, however, any use or disclosure by SCC as permitted by this consent prior to my written revocation shall be deemed authorized and appropriate. I understand I may request a copy of the NOTICES OF PRIVACY PRACTICES from SCC. I understand that it is my responsibility to familiarize myself with the contents of the NOTICE. (A READ-0NLY copy is in the Lobby)

_____ _____ _____

PATIENT/GUARDIAN SIGNATURE DATE PRINTED NAME