CAROLINA CARDIOLOGY ASSOCIATES

PATIENT CONSENT FORM

You may give Carolina Cardiology Associates written authorization to disclose your 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, x-ray, 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:

I give permission for you to provide medical and appointment information for me via the following source(s):

Phone	Text	Portal/Email
O Yes O No	O Yes O No	O Yes O No

Leave detailed message on my home answering machine-phone#: _____

Leave a detailed message on my cell phone voice mail-phone#: _____

Send detailed email to the email address: _____

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:**_____

Consent for Treatment: I consent to the rendering of medical treatment or services as considered necessary and appropriate by the physician, physician assistant, nurse practitioner or designated staff. The consent to receive medical treatment or services includes but is not limited to initial evaluations, assessment evaluations, electrocardiogram, laboratory services or procedures, medications, patient education, and other services in which the patient will receive. I hereby authorize my physician or designated staff to perform diagnostic studies, as a recommended treatment mutually agreed upon by me and to employ such assistance as required providing proper care. Diagnostic testing and services may include but is not limited to echocardiograms, carotid ultrasounds, exercise treadmill test, nuclear stress test, PET/CT scans, vascular and arterial ultrasounds, event monitors and other services recommended by your physician. I am aware that there may be material risks associated with these procedures. If I have any questions or concerns regarding any procedure, I will ask my physician to provide me with additional information. I understand I have the right to see a physician if I so choose and have the right to see a physician prior to any prescription drug or device order being carried out by the physician assistant or nurse practitioner.

Authorized Signature: _____**Date:**_____