CONSENT FORM DEFINITIONS

"Health care operations" refers to large numbers of activities, including:

1. Conducting quality assessment and improvement activities, including outcome evaluation and development of clinical guidelines, provided that the obtaining of generalizable knowledge is not the primary purpose of any studies resulting from such activities; population-based activities relating to improving health care providers and patients with information about treatment alternatives; and related functions that do not include treatment;
2. Reviewing the competence or qualifications or qualifications of health care professionals, evaluating practitioner and provider performance, health plan performance, conducting training programs in which students, trainees, or practitioners in the area of health care learn under supervision to practice or improve their skills as health care providers, training of non-health care professionals, accreditation, certification, licensing, or credentialing activities;
3. Underwriting, premium rating, and other activities relating to creation, renewal or replacement of a contract of health insurance or health benefits, and ceding, securing, or placing a contract for reinsurance of risk relating to claims for health care (including stop-loss insurance and excess of loss insurance);
4. Conducting or arranging for medical review, legal services, and auditing functions, including fraud and abuse detection and compliance programs;
5. Business planning and development, such as conducting cost management and planning-related analyses related to managing and operating the entity, including formulary development and administration, development or improvement of methods of payment or coverage policies; and
6. Business management and general administrative activities including but not limited to: (a) management activities relating to HIPPA privacy rule compliance; (b) customer service, including the provision of data analyses for policy holders, plan sponsor, or customer; (c) resolutions of internal grievances; (d) due diligence in connection with the sale or transfer of assets to a potential successor in interest, if the potential successor in interest is covered entity or, following completion of the sale or transfer, will become a covered entity; and (e) creating de-identified health information, fundraising for the benefit of the covered entity, and marketing for which an individual authorization is not required.

"Payment" means the activities undertaken by the physician to obtain reimbursement for the provision of health care. These activities referred to in this definition relate to whom health care is provided and include, but are not limited to:

1. Determination of eligibility coverage (including coordination of benefits or the determination of cost sharing amounts), and adjudication or subrogation of health benefit claims;
2. Billing, claims management, collection activities, obtaining payment under a contact for reinsurance, and related health care data processing;
3. Review of health care services with respect to medical necessity, coverage under a health plan, appropriateness of care, or justification of charges;
4. Utilization review activities, including precertification and preauthorization of services, concurrent and retrospective review of services; and
5. Disclosure to consumer reporting agencies of any of the following information relating to reimbursement: name and address, date of birth, Social Security number, payment history, account number, and name and address of the physician.

"Treatment" means the provision, coordination, or management of health care and related services by one or more health care providers, including the coordination or management of health care by a health care provider with a third party; consultation between health care providers relating to a patient; or the referral of a patient for health care from one health care provider or another.

"Use" means the sharing, employment, application, utilization, examination, or analysis of patient information within the physician's practice that maintains such information.

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CONSENT FOR RELEASE AND USE OF CONFIDENTAL INFORMATION/NOTICE OF PRIVACY PRACTICE

I, ______________________, hereby give my consent to Consultants in Cardiology & Electrophysiology LLC
(Name of Patient or Authorized Agent)

to use or disclose, for the purpose of carrying out treatment, payment, or health care operations, all information contained in the patient record of ____________________ .
(Patient's name)

I acknowledge receipt of the physician's **Notice of Privacy Practice**. The Notice of Privacy Practice provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved a right to change his or her privacy practices that are described in the Notice. I also understand that a copy of any Revised Notice will be provided by me or made available with each office visit after the change and upon request.

I understand that this consent is valid until it is revoked by me. I understand that I may revoke this consent at any time by giving written notice of my desire to do so, to the physician. I also understand that I will not be able to revoke this consent in cases where the physician has already relied on it to use or disclose my health information. Written revocation of consent must be sent by the physician's office.

Signed: ____ Date: ____________________

If you are not the patient, please specify your relationship to the patient______________________.

Due to Federal HIPPA regulations, Consultants in Cardiology & Electrophysiology LLC may not release any information regarding your condition without your written permission. Please designate any family members and/or persons to whom we may discuss and /or release information relative to your condition and sign below.

I, ________________________________, give Consultants in Cardiology & Electrophysiology LLC and its representatives permission to discuss and/or release my personal and private medical information to/with.

____
Name Address City/State/Zip Phone

Relationship to Patient: ______________________ Patient's Signature: ______________________

____
Name Address City/State/Zip Phone

Relationship to Patient: ______________________ Patient's Signature: ______________________

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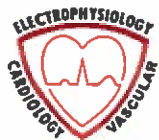

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Authorization Form for Release of Confidential Health Information

I, ______________________________ hereby authorize ______________________________
(Name of patient or authorized agent) (Name of physician, physician's group, or hospital)

the right to release health records to: ______________________________
(Name of Health Care Facility, Physician, Agency, etc.)

____
(Street Address, City, State, and Zip Code)

The following information contained in the patient records of: ______________________________
(Patient's Name)

____
(Date of Birth)

____
(Social Security Number)

residing at: ______________________________
(Street Address, City, State, and Zip Code)

- The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV / acquired immune deficiency syndrome (AIDS) records.
- Stress Test
- Cardiac Catheterization Report
- Cardiac Catheterization Films
- Angioplasty Report
- EKG
- Echo Report
- Holter and / or Event (TTAM) Report
- Surgical Report
- Laboratory Report
- X-Ray Reports
- Tests done in the last month
- Tests done in the last year
- Other: ______________________________

The above information for the following period of time shall be released:
From: ____________________ to ____________________.
Date Date

The purpose(s) of the authorization is (are) ______________________________ I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law. understand that the practice may not condition treatment on whether I sign authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

Signed: ______________________________ Date: ______________
(If you are not the patient, please specify your relationship to the patient)

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I hereby consent for Consultants in Cardiology & Electrophysiology LLC.to deliver, or cause to be delivered, the following types of messages by voice call, text messages, email and/or mail using automated telephone dialing systems and/or artificial and prerecorded voice:

- Appointment Reminders
- Visit Recalls
- Balance Reminders

I authorize such messages to be delivered to the following:

Cell Phone ________________________________

Email ____________________________________

Landline __________________________________

By acknowledgement and signing this consent form, I am granting permission to Consultants in Cardiology & Electrophysiology LLC. to deliver or cause to be delivered to me certain text messages and/or voice calls.

**I am not required to sign this agreement in order to receive services from Consultants in Cardiology & Electrophysiology LLC.

** Additionally, you retain the right to revoke permission at any time.

____
Signature

____
Printed Name

____
Date

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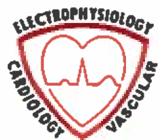

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____
(Street Address, City, State, and Zip Code)

The following information contained in the patient records of: ______________________________
(Patient's Name)

____
(Date of Birth)

____
(Social Security Number)

residing at: ______________________________
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- The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV / acquired immune deficiency syndrome (AIDS) records.
- Stress Test
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- Cardiac Catheterization Films
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- Surgical Report
- Laboratory Report
- X-Ray Reports
- Tests done in the last month
- Tests done in the last year
- Other: ______________________________

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