

Midwest Cardiology Associates

Patient's name (Print): _____ Date of Birth: _____

CONSENT TO USE AND DISCLOSURE OF HEALTH INFORMATION

By signing this form, you are granting consent to Midwest Cardiology Associates to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting us at 913. 253-3000. You have a right to request that we restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent. _____

Patient Initials Date

ACKNOWLEDGEMENT OF RECEIPT OF NOTICE OF PRIVACY

I received Midwest Cardiology's NOTICE OF PRIVACY PRACTICES. _____
Patient Initials Date

ACKNOWLEDGEMENT OF APPOINTMENT MESSAGE

I give permission for Midwest Cardiology to leave 'appointment reminders' on my answering machine or the person answering the 'reminder call'

Patient Initial Date

MIDWEST CARDIOLOGY CAN DISCLOSE HEALTH INFORMATION TO THE FOLLOWING:

I give my consent for Midwest Cardiology to disclose my Health information to the following people:

Person(s) full name: _____

Patient's Signature: _____ Date: _____

* _____
Legal representatives' signature Relationship Date

* If patient cannot act for themselves, a spouse, legal guardian, power of attorney, and other needs to sign.

I hereby authorize Midwest Cardiology Associates to obtain any available prescription and/or medication history about me that may be available via an electronic prescribing hub that compiles information from electronic-enabled pharmacies nationwide. I understand that Midwest Cardiology may receive up to two years worth of my prescription history from the hub. I understand that the information received electronically may not be complete and that it is in my best interest to provide Midwest Cardiology Associates with a full list of all medications I am taking.

Patient Name

Date of Signature

Signature