Consent for Release of Protected Health Information

I, ________________________________, ____/____/____

(Patient Name) (Date of Birth)

Consent to the release of protected health information that is required to carry out treatment, or for payment of healthcare operations on my behalf. I have received a copy of the Notice of Privacy Practices and am aware of the following:

- I retain the right to request limitations on the use and disclosure of my protected health information.
- I understand that once **Heart One Associates** agrees to any requested restrictions, they are legally obligated to honor those restrictions.
- I reserve the right to revoke this consent at any time by submitting a signed written request to **Heart One Associates**.
- I acknowledge that **Heart One Associates** will honor my revocation of consent immediately, except where actions have already been taken in reliance on my original consent.
- **Heart One Associates** reserves the right to periodically update its privacy practices as outlined in the Notice of Privacy Practices. Any amendments will be reflected in an updated Notice, and patients will be informed accordingly.

I consent to discuss my protected health information with the following authorized party(ies): YES [ ] NO [ ]

Name of Authorized Party ____________________________ Phone Number ____________________

Relationship ____

Name of Authorized Party ____________________________ Phone Number ____________________

Relationship ____

Name of Authorized Party ____________________________ Phone Number ____________________

Relationship ____

Patient Name (Print) ____________________________ Signature ____________________________ Date ____________

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