

EAST ATLANTA CARDIOLOGY

Name _____ DOB _____

HIPAA, Health Insurance Portability & Accountability Act of 1996, requires healthcare organizations to comply with specific rules. Of significant concern is the Administrative Simplification section of the Act which is in regards to:

- Healthcare Transaction & Code Sets for Transmitting data electronically
- Unique Identifiers for health plan, providers, individuals, and employers
- Security regulations over protections of electronics health information
- Privacy regulations over disclosure and use of health information

I have read and understand the "Notice of Information Practices" that provides a complete description of information uses and disclosures, posted in the lobby reception room. I understand that upon request I will be provided a copy of such notice. It is the policy of East Atlanta Cardiology not to release confidential and/or unauthorized information by home telephone, answering machine, work telephone, voice mail, cell phone, or pager unless authorized by me. (Except appointment reminders including dates, times, and doctor's name only) Return phone calls left on answering machines will only include our name and phone number. Information will not be left with an unauthorized person who answers the phone. This consent will expire on ____/____/____.

I authorize East Atlanta Cardiology to leave the medical information pertaining to my care by the following methods and will assume responsibility to notify them whenever this information changes:

Home # _____ Yes ____ No ____

Work # _____ Yes ____ No ____

Cell/voicemail# _____ Yes ____ No ____

Answering Machine Yes ____ No ____

Can we fax medical records for referrals? Yes ____ No ____

If you authorize information released to someone other than yourself please complete the following:

Spouse _____

Phone# _____

Parent _____

Phone# _____

Other _____ Relation _____

Phone# _____