JEFFERSON CARDIOLOGY ASSOCIATION

Greater Pittsburgh Vascular Associates

CONSENT FOR RELEASE
JEFFERSON CARDIOLOGY ASSOCIATION / GREATER PITTSBURGH VASCULAR ASSOCIATES

CONSENT FOR RELEASE AND USE OF CONFIDENTIAL INFORMATION AND RECEIPT OF NOTICE OF PRIVACY PRACTICES FORM

I, _____, hereby give my consent to:

JEFFERSON CARDIOLOGY ASSOCIATION / GREATER PITTSBURGH VASCULAR ASSOCIATES

To use or disclose, for the purpose of carrying out treatment, payment, or healthcare operations, all information contained in the patient record of:

_____

(patient's name)

I grant permission to view my prescription history from external sources (other physicians.) I consent to report Immunizations to the USA. I have been notified of the physician's Notice of Privacy Practices, which is available at the front desk. The Notice of Privacy Practices provides detailed information about how the practice may use and disclose my confidential information.

I understand that the physician has reserved the 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 to me or made available at the time of the appointment.

I understand that 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 to the physician's office.

SIGNED: _____ DATE: _____

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

_____

- Patient's file

OFFICE USE ONLY

I attempted to obtain the patient's signature in acknowledgement on this Notice of Privacy Practices Acknowledgement, but was unable to do so as documented below:

DATE: _____ INITIAL: _____

REASON: _____