Cardiology of Atlanta Patient Information

PATIENT INFORMATION			
NAME (Last, First, Middle)	SSN #	BIRTHDATE	SEX

LOCAL ADDRESS	**PHARMACY NAME**
CITY, STATE, ZIP	ADDRESS
HOME PHONE	CITY, STATE, ZIP
PRIMARY EMPLOYER	PHONE #
ADDRESS	Fax #
CITY, STATE, ZIP	Annual Electronic Prescription Consent Yes ☐ No ☐
WORK PHONE	
EMERGENCY CONTACT NAME	PHONE #
PRIMARY CARE PROVIDER NAME	PHONE #

RESPONSIBLE PARTY INFORMATION (If Different that above)			
NAME (Last, First, Middle)	SSN #	BIRTHDATE	SEX

CITY, STATE, ZIP
HOME PHONE
RELATIONSHIP TO PATIENT

PRIMARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE, ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

SECONDARY INSURANCE		
NAME OF INSURANCE COMPANY	POLICY #	
NAME OF INSURED	GROUP #	
ADDRESS OF INSURANCE COMPANY	COPAY AMT	
CITY, STATE, ZIP	DEDUCTIBLE	
RELATIONSHIP TO PATIENT	EFFECTIVE DATE	EXPIRATION DATE

_____ _____

SIGNATURE OF PATIENT/GUARDIAN DATE .

AUTHORIZATION TO DISCLOSE
PRIVATE HEALTH CARE INFORMATION

Name of Patient: _____ Date of Birth: _____

Address: _____ City/State/Zip: _____

Home Phone: _____ Work/Cell: _____

I authorize: **Cardiology of Atlanta, P.C.**

755 Mt. Vernon Highway, Suite 530
Atlanta, Georgia 30328
Phone: 404/252-7970
Fax: 404/250-0553

Joseph Wilson M.D., F.A.C.C.
Hector A. Malave, M.D., F.A.C.C.
Matthew J. Wilson, M.D.

To use and/or disclose my private health care information as described below to:

Name: _____

(name of person, class of persons, or organization to whom your protected health information may be disclosed)

Address: _____ City/State/Zip: _____

The type and amount of information to be used or disclosed is as follows: (please check those that apply):

HEALTH CARE INFORMATION NEEDED

___Hospital Medical Records
___History & Physical/Consultations/Progress Notes
___Radiology/Imaging Reports and/or Radiology Films
___Laboratory/Pathology Reports
___Alcohol/Drug Records and/or HIV Test Results
___Complete Medical Record
___Billing Records
___A Representative of COA may discuss my PHI

Disclosure purpose: _____

Records for the following should be included:

Date(s) of service or period of time: _____

Doctor: _____

I authorize the release of information in my health record which may include information relating to:

___Sexually transmitted disease
___HIV/AIDS –related information (CGS 19a-585(a)
___Mental health services (CGS 52-146(d)
___Alcohol/substance abuse (42CFR 2.1-2.67)

I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the Medical Records Department. Additional information regarding the individual's right to revoke an authorization is found in COA's Notice of Privacy Practices.

This authorization will expire on the following date: _____

I understand that authorizing disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to receive treatment, payment for services, enrollment or eligibility for benefits from COA. I understand that I may inspect or copy the information to be used or disclosed, as provided in 45 CFR 164.524. I understand COA may charge a processing fee for copying services.

If I have questions about disclosure of my health information, I can contact the Medical Record Department at Cardiology of Atlanta.

_____ _____
Signature of Patient or Patient's Representative Date

_____ _____
Printed Name of Patient or Patient's Representative

_____ or _____
Relationship to Patient Legal Authority (Attach Documentation)

Disclosure of Protected Health Information

The HIPAA privacy rule gives individuals the right to request a restriction on uses and disclosures of their protected health information (PHI). The individual is also provided the right to request confidential communications or that a communication of PHI is made by alternative means.

I WISH TO BE CONTACTED IN THE FOLLOWING MANNER (CHECK ALL THAT APPLY):

- ☐ Home Telephone _____
  - ☐ OK to leave message w/detailed information
  - ☐ Leave message with call-back number only
- ☐ Work Telephone _____
  - ☐ OK to leave message with detailed information
  - ☐ Leave message with call-back number only
- ☐ Written Communication
  - ☐ OK to mail to my home address
  - ☐ OK to mail to my work address
- ☐ OK to fax to designated number
  Fax number _____

I authorize the following person(s) to discuss my health care information:

_____

_____

_____

_____

_____

I understand that I have the right to revoke this authorization at any time, expect to the extent that the person(s) to whom I have authorized such use/or disclosure have acted in reliance upon this authorization. In order to revoke this authorization, I must provide CARDIOLOGY of Atlanta, P.C. in writing, specifically revoking this authorization.

_____ _____

Patient Signature Date

_____

Please Print Patient Name

NOTICE OF PRIVACY POLICIES
FOR CARDIOLOGY OF ATLANTA

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Introduction

At **Cardiology of Atlanta**, we are committed to treating and using protected health information about you responsibly. This Notice of Health Information Practices describes the personal information we collect, and how and when we use or disclose that information. It also describes your rights as they relate to your protected health information. This Notice is effective January 1, 2008, and applies to all protected health information as defined by federal regulations.

Understanding Your Health Record/Information

Each time you visit Cardiology of Atlanta, a record of your visit is made. Typically, this record contains your symptoms, examination and test results, diagnoses, treatment, and a plan for future care or treatment. This information, often referred to as your health or medical record, serves as a:

- Basis for planning your care and treatment,
- Means of communication among the many health professionals who contribute to your care,
- Legal document describing the care you received,
- Means by which you or a third-party payer can verify that services billed were actually provided,
- A tool in educating health professionals,
- A source of data for medical research,
- A source of information for public health officials charged with improving the health of this state and the nation,
- A source of data for our planning and marketing,
- A tool with which we can assess and continually work to improve the care we render and the outcomes we achieve,

Understanding what is in your record and how your health information is used helps you to: ensure its accuracy, better understand who, what, when, where, and why others may access your health information, and make more informed decisions when authorizing disclosure to others.

Your Health Information Rights

Although your health record is the physical property of Cardiology of Atlanta, the information belongs to you. You have the right to:

- Obtain a paper copy of this notice of information practices upon request,
- Inspect and copy your health record as provided for in 45 CFR 164.524,
- Amend your health record as provided in 45 CFR 164.528,
- Obtain an accounting of disclosures of your health information as provided in 45 CFR 164.528,
- Request communications of your health information by alternative means or at alternative locations,
- Request a restriction on certain uses and disclosures of your information as provided by 45 CFR 164.522, and
- Revoke your authorization to use or disclose health information except to the extent that action has already been taken.

Our Responsibilities

Cardiology of Atlanta is required to:

- Maintain the privacy of your health information,
- Provide you with this notice as to our legal duties and privacy practices with respect to information we collect and maintain about you,
- Abide by the terms of this notice,
- Notify you if we are unable to agree to a requested restriction, and

- Accommodate reasonable requests you may have to communicate health information by alternative means or at alternative locations.

We reserve the right to change our practices and to make the new provisions effective for all protected health information we maintain. Should our information practices change, we will mail a revised notice to the address you've supplied us, or if you agree, we will email the revised notice to you.

We will not use or disclose your health information without your authorization, except as described in this notice. We will also discontinue to use or disclose your health information after we have received a written revocation of the authorization according to the procedures included in the authorization.

For More Information or to Report a Problem
If you have questions and would like additional information, you may contact the practice's Privacy Officer, Terri Wynn (404) 252-7970

If you believe your privacy rights have been violated, you can file a complaint with the practice's Privacy Officer, or with the Office for Civil Rights, U.S. Department of Health and Human Services. There will be no retaliation for filing a complaint with either the Privacy Officer or the Office for Civil Rights. The address for the OCR is listed below:

Office for Civil Rights
U.S. Department of Health and Human Services
200 Independence Avenue, S.W.
Room 509F, HHH Building
Washington, D.C. 20201
Examples of Disclosures for Treatment, Payment and Health Operations

We will use your health information for treatment.

For example: Information obtained by a nurse, physician, or other member of your health care team will be recorded in your record and used to determine the course of treatment that should work best for you. Your physician will document in your record his or her expectations of the members of your health care team. Members of your health care team will then record the actions they took and their observations. In that way, the physician will know how you are responding to treatment.

We will also provide your physician or a subsequent health care provider with copies of various reports that should assist him or her in treating you once you're discharged from the hospital.

We will use your health information for payment.

For example: A bill may be sent to you or a third-party payer. The information on or accompanying the bill may include information that identifies you, as well as your diagnosis, procedures, and supplies used.

We will use your health information for regular health operations.

For example: Members of the medical staff, the risk or quality improvement manager, or members of the quality improvement team may use information in your health record to assess the care and outcomes in your case and others like it. This information will then be used in an effort to continually improve the quality and effectiveness of the healthcare and service we provide.

Business associates: There are some services provided in our organization through contacts with business associates. Examples include physician services in the emergency department and radiology, certain laboratory tests, and a copy service we use when making copies of your health record. When these services are contracted, we may disclose your health information to our business associate so that they can perform the job we've asked them to do and bill you or your third-party payer for services rendered. To protect your

health information, however, we require the business associate to appropriately safeguard your information.

Directory: Unless you notify us that you object, we will use your name, location in the facility, general condition, and religious affiliation for directory purposes. This information may be provided to members of the clergy and, except for religious affiliation, to other people who ask for you by name.

Notification: We may use or disclose information to notify or assist in notifying a family member, personal representative, or another person responsible for your care, your location, and general condition. We may also use or disclose information to confirm appointments.

Communication with family: Health professionals, using their best judgment, may disclose to a family member, other relative, close personal friend or any other person you identify, health information relevant to that person's involvement in your care or payment related to your care.

Research: We may disclose information to researchers when their research has been approved by an institutional review board that has reviewed the research proposal and established protocols to ensure the privacy of your health information.

Funeral directors: We may disclose health information to funeral directors consistent with applicable law to carry out their duties.

Organ procurement organizations: Consistent with applicable law, we may disclose health information to organ procurement organizations or other entities engaged in the procurement, banking, or transplantation of organs for the purpose of tissue donation and transplant.

Marketing: We may contact you to provide appointment reminders or information about treatment alternatives or other health-related benefits and services that may be of interest to you.

Fund raising: We may contact you as part of a fund-raising effort.

Food and Drug Administration (FDA): We may disclose to the FDA health information relative to adverse events with respect to food, supplements, product and product defects, or post marketing surveillance information to enable product recalls, repairs, or replacement.

Workers compensation: We may disclose health information to the extent authorized by and to the extent necessary to comply with laws relating to workers compensation or other similar programs established by law.

Public health: As required by law, we may disclose your health information to public health or legal authorities charged with preventing or controlling disease, injury, or disability.

Law enforcement: We may disclose health information for law enforcement purposes as required by law or in response to a valid subpoena.

Federal law makes provision for your health information to be released to an appropriate health oversight agency, public health authority or attorney, provided that a work force member or business associate believes in good faith that we have engaged in unlawful conduct or have otherwise violated professional or clinical standards and are potentially endangering one or more patients, workers or the public.

Acknowledgement Receipt of Privacy Notice

I have been provided a copy of the Notice of Privacy Practices for **Cardiology of Atlanta, P.C.**

Signature of Patient or Patient's Representative

Date

Printed Name of Patient or Patient's Representative

If Applicable, Relationship to Patient