2410 Atherholt Road
Lynchburg, VA 24501
(434) 544-2331 or (434) 200-5252

Consent to the Use and Disclosure of Health Information for Treatment, Payment, or Healthcare Operations

I, ____________________________, understand that as part of my healthcare, this practice originates and maintains health records describing my health history, symptoms, examination and test results, diagnoses, treatment, and any plans for future care or treatment. I understand this information serves as:

> A basis for planning my care and treatment; a means of communication among the many health professionals who contribute to my care; a source of information for applying my diagnosis and surgical information to my bill; a means by which a third-party payer can verify that services billed were actually provided; and a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

I authorize the release of any medical information to my insurance carrier which is necessary to process my insurance claims. I also authorize my insurance benefits to be paid directly to my physician, realizing I am responsible to pay for non-covered services.

I understand and have been provided with a Notice of Privacy Practices that provides a more complete description of information uses and disclosures. I understand that the organization is not required to agree to the restrictions requested. I understand that I may revoke this consent in writing; except to the extent that the organization has already taken in reliance thereon.

I request the following restrictions to the use and disclosure of any health information:

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I authorize the release of my laboratory results or tests, scheduling or changing appointments and reminders of upcoming appointments, to verify if I am ready to be picked up from my visit and/or to pick up prescriptions, to speak to the Finance Department in regard to my account/billing and any other special requests to:
(1)____ Relationship ______________________________
(2)____ Relationship ______________________________
(3)____ Relationship ______________________________

I authorize The Cardiovascular Group of Central Virginia to send reminder notices of upcoming appointments to me or to leave messages on my telephone answering machine.
Yes __________ No __________

I fully understand and accept/decline the terms of this consent.

____________________________________ _______ ____________________________
Signature DOB Date