PARKWAY CARDIOLOGY ASSOCIATES, P.C.
PATIENT HIPAA RELEASE & CONSENT FOR TREATMENT / TESTING

Patient Name _____ Birth Date _____
First Middle Last

Release of Information

I, hereby, give Parkway Cardiology Associates permission to divulge my personal health information to the following (please indicate relationship). If additional space is needed, please attach a separate sheet.

_____ _____

_____ _____

Before releasing information, we may ask for your social security number and date of birth. Please make certain that they have this information before calling our office.

I, hereby, give my permission for your office to leave messages as indicated.

Yes	No	
☐	☐	My home phone answering machine (where anyone may access the message)
☐	☐	My office answering machine
☐	☐	N/A (I do not have an answering machine.)
☐	☐	I give my permission for you to leave messages with anyone who answers my home phone.

Consent for Treatment and Testing

I, hereby, consent to medical treatment including routine diagnostic procedures and blood testing when considered necessary. ***Release of Records:*** I, hereby, authorize you to release any information, including diagnosis and the record of any treatment or examination rendered to me or my child during the period of such care, to third party payers and/or health practitioners. ***Minors:*** If the patient is a minor (under 18 years of age), the legal guardian has authorized (by signing below) the treatment of the minor. ***Assignment:*** I authorize and request my insurance company, to pay insurance benefits, otherwise payable to me directly, to the physician. I understand that my insurance carrier may pay less than the actual bill for services. I agree to be responsible for payment of all services rendered on my behalf or my dependents.

Privacy Notice Release

I have received, or have been offered, a copy of Parkway Cardiology Associates' "Privacy Practices for Protected Health Information".

Patient Signature _____ *Date* _____