



# Cardiology of Virginia, Inc.

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## Consent for Use and Disclosure of Protected Health Information

Patient's Name: \_\_\_\_\_

We use information that you provide us, including health information, to carry out treatment, payment, and healthcare options. Please refer to our "Notice of Privacy Practices" for a more complete description. You have the right to review the notice before signing this consent.

The terms of our Notice of Privacy Practices may change. You may obtain a revised notice from our receptionist or by calling our privacy officer at 560-8782.

You have the right to request that we restrict the use of your health information to carry out treatment, payment, or healthcare operations. We are not required to agree to the restriction. If we do agree to any restrictions, the agreement is binding on use.

You have the right to revoke this consent at any time by notifying us in writing. The revocation will not have any effect on any actions taken in reliance on the consent prior to the time you revoke it.

***I understand and have been provided a copy of a Notice of Privacy Practices that provides a more complete description of information uses and disclosures.***

***I hereby consent to the use and disclosure of my individually identifiable health information for treatment, payment, and healthcare operation purposes.***

***I give Cardiology of Virginia permission to discuss my medical information with the following people:***

Name:	Relationship:
Name:	Relationship:
Name:	Relationship:

\_\_\_\_\_  
Signature of patient or patient's representative

\_\_\_\_\_  
Date