ascent
cardiovascular
center

office 813.540.4322
fax 813.540.7262
hello@ascentcardiology.com
www.ascentcardiology.com

Welcome!

Thank you for choosing **Ascent Cardiovascular Center** for your care. Enclosed you will find helpful information regarding your upcoming visit.

For your convenience we are pleased to send copies of the **Welcome Packet**, **Patient Registration Form**, and **New Patient Intake Form** in advance of your visit. You will also find other forms to review and sign. You will be receiving a reminder call from our office prior to your appointment.

Please make sure your completed forms include your primary ***and*** referring physicians' names, addresses and phone/fax numbers so we can communicate with your providers.

In addition, to care for you efficiently and to avoid delays in evaluating your condition, it is essential that you bring the following to your office visit:

1. **Your insurance card(s)**
2. **Picture ID**
3. **Applicable cardiac and medical records**

If a referral is required by your insurance carrier, please make certain to contact your primary care physician to have a fax sent to us at **813.540.7262** or, alternatively, submit the referral electronically.

Please contact us by phone at **813.540.4322** with any questions regarding your appointment or directions to our office.

We look forward to seeing you!

The Providers and Staff
Ascent Cardiovascular Center

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Preparing for Your Visit

In order to make your experience as pleasant and efficient as possible, we encourage you to plan to arrive at our office 15 minutes before your appointment time to complete the registration process.

As a reminder, if your insurance requires a referral, please be sure to bring it with you to your appointment. Also, please bring your insurance card(s).

To ensure that your provider has the information needed to provide you with the highest quality care, please arrange to have any pertinent medical records or test results from other doctors sent over to the practice at least one week before your appointment.

Medical records and test results may be emailed or faxed to the practice in advance of your appointment.

During Your Visit

Registration

Please sign-in at the front desk upon arrival. The front desk staff will verify your personal information, provide you with any forms necessary for your visit, if not already completed, and inform the medical assistant of your arrival.

In order to ensure that your visit will be covered under your insurance policy, we will need to confirm your personal information at each visit to our practice. This will minimize your out-of-pocket costs.

If your insurance company requires a referral, please present it to the front desk staff. Any co-pays or other fees required by your insurance will be collected at your appointment. We accept all major credit cards.

Waiting Room

We know your time is valuable and we will make every effort to see you at your scheduled appointment time. Unfortunately, emergencies, complications, and other issues may lead to unexpected delays.

If your provider is running more than 15 minutes late, a member of our staff will advise you of the expected wait time. If you are waiting more than 15 minutes and no one has come to speak with you, please inform the front desk staff.

Exam Room

Once you are in the exam room, a medical assistant will ask you preliminary questions and record your vital signs. If your provider is delayed, the medical assistant will keep you informed. Depending on the nature and complexity of your tests, the timing of results may vary widely. If your doctor orders tests during your appointment, please ask when you should expect to hear about the results.

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After Your Visit

Between Appointments

If you need to speak with your provider between visits, please allow up to 48 hours for any non-urgent calls to be returned. Your provider's medical secretary can help you with prescription refills. Please allow one complete business day for us to contact your pharmacy.

If you need a referral or an authorization for a procedure, please allow three complete business days for us to process this. If you have a form that needs to be completed by your doctor, please allow two weeks for this to be processed.

Follow-Up and Future Appointments

Please try to schedule all routine appointments as far in advance as possible. If your provider of choice does not have an appointment convenient to your schedule, our schedulers may suggest their professional colleague. As members of a group practice all of our providers collaborate and communicate frequently to ensure continuity of care across the practice. If you will be undergoing additional specialized cardiac testing, please allow 4-6 weeks before the provider will review your results with you. This amount of time is required to allow for completion of the testing and interpretation by the physician. If any of your cardiac tests reveal significant abnormalities, you will be notified by our office and scheduled for an urgent visit to review the results with one of our providers.

Your Bill

If you have any questions when you receive your bill, please contact our billing department at 813.540.4322 or via email at billing@ascentcardiology.com. We will make every effort to respond within 24-48 hours.

Questions

If you have any questions or concerns regarding any aspect of your visit, please call and ask to speak with the practice manager.

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PATIENT REGISTRATION FORM

(Please Print)

PATIENT INFORMATION

Last Name: _____ First Name: _____ MI: _____

Gender: _____ Social Security: _____ Date of Birth: _____

Address: _____ Apt #: _____ City: _____ State: _____

Zip: _____ Phone: (Home): _____ (Mobile): _____

(Work): _____ Email: _____

Marital Status: Married _____ Single _____ Other _____ Translator Required: Y / N. If Yes, specify language: _____

Employment: Full Time ____ Part Time ____ Retired ____ Not Employed ____ School ____ Disability ____

Employer: _____ Phone: _____

Address: _____ City: _____ State: _____ Zip: _____

SPOUSE INFORMATION

Last Name: _____ First Name: _____ MI: _____

Phone: (Home): _____ (Mobile): _____

Date of Birth: _____

PARENT INFORMATION

(This section is only applicable to full time students or for individuals covered under their parent's/guardian's health insurance policy. Please provide the below information on the parent of which you are covered under.)

Parent Last Name: _____ First Name: _____ MI: _____ Gender: _____

Date of Birth: _____

Address: _____ Apt #: _____ City: _____ State: _____ Zip: _____

Phone: (Home):_____ (Mobile): _____ (Work): _____

Employer: _____

EMERGENCY CONTACT

Last Name: _____ First Name: _____ Gender: _____

Relationship to Patient: _____ Primary Number: _____ Secondary Number: _____

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Patient Name: _____ DOB: _____

PRIMARY CARE PHYSICIAN (PCP)

Physician Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Fax: _____

REFERRING PROVIDER (If not PCP)

Provider Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone Number: _____

Fax: _____

PHARMACY INFORMATION

Name of Pharmacy: _____

Address: _____ City: _____ State: _____ Zip_____

Phone Number: _____

PRIMARY INSURANCE INFORMATION

Primary Insurance Company Name: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Subscriber ID #:_____ Group #:_____

Patient's relationship to insured: Self / Spouse / Child / Other

Insured Name (if not self):_____ SS#:_____ Date of Birth: _____

SECONDARY INSURANCE INFORMATION

Secondary Insurance Company Name: _____

Claims Address: _____ City: _____ State: _____ Zip: _____

Subscriber ID: _____ Group Number: _____

Patient's relationship to insured: Self / Spouse / Child / Other

Insured Name (if not self):_____ SS#:_____ Date of Birth:_____

HOW DID YOU HEAR ABOUT OUR PRACTICE

Please check One: Referring Physician: _____ Hospital: _____ Family/Friend: _____

Insurance Company: _____ Internet _____ Other: _____

New Patient Intake Form

Name: _____ Date: _____

Date of Birth: _____ Age: _____ Occupation: _____

Marital Status: ☐ Single ☐ Married ☐ Divorced ☐ Widowed

Birth Place: _____ Education Level: _____

Reason for Cardiac Referral: _____

Physician referring for Cardiac assessment: _____

Have you seen a Cardiologist (heart doctor) before? ☐ Yes ☐ No

If so, please ask them to fax your records to our office or bring your records with you.

Prior Cardiac History

Do you currently have or have ever had any of the following cardiac or related issues?

Arrhythmias	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Atrial fibrillation	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Cardiomyopathy	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Congenital heart disease	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Congestive heart failure	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Coronary artery disease	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Coronary artery stents	☐ Yes ☐ No	When implanted? _____ How many? _____
Endocarditis	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Hypertension	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Hyperlipidemia	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Pacemaker or Defibrillator	☐ Yes ☐ No	When implanted? _____ What company? _____
Peripheral arterial disease	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Prior heart attack	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Rheumatic heart disease	☐ Yes ☐ No	When diagnosed? _____ How treated? _____
Valvular heart disease	☐ Yes ☐ No	When diagnosed? _____ How treated? _____

Prior Medical History

Anemia	☐ Yes ☐ No	
Asthma	☐ Yes ☐ No	
Autoimmune disorder	☐ Yes ☐ No	What type? _____
Bleeding disorder	☐ Yes ☐ No	What type? _____
Cancer	☐ Yes ☐ No	What type? _____
Chronic kidney disease	☐ Yes ☐ No	How treated? _____ What stage? _____
COPD/Emphysema	☐ Yes ☐ No	
Diabetes mellitus	☐ Yes ☐ No	
Hypothyroidism	☐ Yes ☐ No	
Hyperthyroidism	☐ Yes ☐ No	
GERD	☐ Yes ☐ No	
Osteoarthritis	☐ Yes ☐ No	
Peptic ulcer disease	☐ Yes ☐ No	
Prior stroke or TIA	☐ Yes ☐ No	When diagnosed? _____

Have you ever had the following cardiac testing or procedures performed?

If you have please bring a copy of the results with you, if available.

Cardiac catheterization	☐ Yes ☐ No	When and Where? _____
Echocardiogram	☐ Yes ☐ No	When and where? _____
Holter or Event monitor	☐ Yes ☐ No	When and where? _____
Nuclear stress test	☐ Yes ☐ No	When and where? _____
Treadmill stress test	☐ Yes ☐ No	When and where? _____
Cardiac/Coronary CT	☐ Yes ☐ No	When and where? _____
Cardiac MRI	☐ Yes ☐ No	When and where? _____

Surgical History

Type of Surgery	*When*	*Where*
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

Social History

Do you currently work? ☐ Yes ☐ No

Are you retired? ☐ Yes ☐ No If retired, what was your previous occupation? _____

Do you currently or have you ever consumed alcohol? ☐ Yes ☐ No

If yes, which type, how much, and how often? _____

Do you currently use or have previously used (smoke or chewing) tobacco? ☐ Yes ☐ No

Cigarettes: ☐ Yes ☐ No _____ Packs per day for _____ years. Quit date _____.

Cigars: ☐ Yes ☐ No _____ Cigars per day for _____ years. Quit date _____.

Do you currently use or have previously used illicit drugs? ☐ Yes ☐ No

If yes, which type(s) and how often? _____

Do exercise on a regular basis? ☐ Yes ☐ No

Duration and Frequency? _____

How many blocks can you walk at a regular pace without stopping? _____

How many flights of stairs can you walk up without stopping? _____

Current diet/special diet? _____

Family History

Has anyone in your family (mother, father or sibling) had "sudden cardiac death" or died at a young age inexplicably? ☐ Yes ☐ No If yes, at what age? _____

Mother:

If living, current age: _____ *If deceased*, age at death: _____ Cause of death: _____

History of heart disease: ☐ Yes ☐ No If yes, what age diagnosed? _____

- ☐ Arrhythmias
- ☐ Cancer
- ☐ Cardiomyopathy
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Diabetes mellitus
- ☐ High cholesterol
- ☐ Hypertension

Father:

If living, current age: _____ *If deceased*, age at death: _____ Cause of death: _____

History of heart disease: ☐ Yes ☐ No If yes, what age diagnosed? _____

- ☐ Arrhythmias
- ☐ Cancer
- ☐ Cardiomyopathy
- ☐ Congestive Heart Failure
- ☐ Coronary Artery Disease
- ☐ Diabetes mellitus
- ☐ High cholesterol
- ☐ Hypertension

Siblings:

Age: _____ Sex: _____ Health issues: _____

Age: _____ Sex: _____ Health issues: _____

Age: _____ Sex: _____ Health issues: _____

Review of Systems

Are you currently having or have you previously had the following problems?

Abdominal pain	☐ Yes	☐ No	Details _____
Anxiety	☐ Yes	☐ No	Details _____
Arthritis	☐ Yes	☐ No	Details _____
Awakening at night with shortness of breath	☐ Yes	☐ No	Details _____
Black and Tarry Stools	☐ Yes	☐ No	Details _____
Blood in Stool	☐ Yes	☐ No	Details _____
Blood clots in legs or lungs	☐ Yes	☐ No	Details _____
Blood in Urine	☐ Yes	☐ No	Details _____
Blood Transfusions	☐ Yes	☐ No	Details _____
Chest pain, discomfort or pressure	☐ Yes	☐ No	Details _____
Chronic Bronchitis	☐ Yes	☐ No	Details _____
Depression	☐ Yes	☐ No	Details _____
Difficulty Hearing	☐ Yes	☐ No	Details _____
Dizziness	☐ Yes	☐ No	Details _____
Excessive Bleeding	☐ Yes	☐ No	Details _____
Excessive urination	☐ Yes	☐ No	Details _____
Eye Pain	☐ Yes	☐ No	Details _____
Fatigue / Feeling tired	☐ Yes	☐ No	Details _____
Fevers or Chills	☐ Yes	☐ No	Details _____
Frequent and/or productive cough	☐ Yes	☐ No	Details _____
Headache	☐ Yes	☐ No	Details _____
Indigestion or Heartburn	☐ Yes	☐ No	Details _____
Irregular heart rate	☐ Yes	☐ No	Details _____
Jaw pain	☐ Yes	☐ No	Details _____
Leg pain w/exertion (leg claudication)	☐ Yes	☐ No	Details _____
Nausea or vomiting	☐ Yes	☐ No	Details _____
Neck pain	☐ Yes	☐ No	Details _____
Nervousness	☐ Yes	☐ No	Details _____
Numbness or tingling in extremities	☐ Yes	☐ No	Details _____
Palpitations	☐ Yes	☐ No	Details _____
Shortness of breath	☐ Yes	☐ No	Details _____
Sleep w/ extra pillows or sleeping upright	☐ Yes	☐ No	Details _____
Swelling in legs, hands and/or feet	☐ Yes	☐ No	Details _____
Syncope (fainting)	☐ Yes	☐ No	Details _____
Vision Problems	☐ Yes	☐ No	Details _____
Weight change	☐ Yes	☐ No	Details _____
Wheezing	☐ Yes	☐ No	Details _____

Current Medications

Including over the counter medications, vitamins, and herbal supplements.

Please bring all of your medications with you to your appointment.

Name of medication	*Dosage*	*How often?*

Allergies

Medication/Food/Item Allergic:	*Reaction*

Patient Signature _____ **Date** _____

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Office Policies And Procedures

Thank you for choosing Ascent Cardiovascular Center for your cardiovascular care.

We realize that you have a choice in medical providers and are pleased that you have chosen to seek your care with us. The staff at Ascent Cardiovascular Center strives to exceed expectations in care and service in order to make your experience with us comfortable and stress free. Please feel free to contact our office if you have any questions concerning our policies.

Office Hours

Our office staff is available Monday-Friday, 9:00 am to 5:00 pm*, (excluding holiday schedules and closures) and may be reached at (813) 540-4322 for routine matters such as appointment scheduling, prescription refills, and other non-emergency matters. An answering service is available to assist you after these scheduled office hours. In the event of a medical emergency, please call 911.

Our patient coordinators and clinical staff will always assist you to the best of their abilities during office hours. However, on clinic days, questions or messages requiring the attention of the clinical staff will be answered within 48 hours.

Appointments

When calling for an appointment, please be prepared to provide our patient coordinators with your chief complaint/reason for the visit, referring physician (if applicable) as well as any updated contact or insurance information.

While we strive to schedule appointments appropriately, emergencies can occur in specialty medicine, and our providers will always give each of their patients the time they require for their unique medical problem. For this reason, we kindly request your patience and understanding should a delay or rescheduling be necessary on your appointment date.

Cancellations

It is the policy of this office that **cancellations must be made within 24 hours** of scheduled appointments. **It is every patient's responsibility to remember their scheduled appointments.** Reminder calls are an office courtesy and should not be solely relied on. In the event that your appointment is not canceled, a no-show fee may be added to your account. All no-show appointments are automatically rescheduled in 2 to 4 weeks to prevent lapses in patient care and for continuity of care. When a patient fails to cancel to an office visit in a timely manner, our office staff resources including staff time and equipment could otherwise be dedicated to other patients with limited access to our services.

Insurance

As a courtesy to our patients, Ascent Cardiovascular Center is happy to file insurance claims on your behalf. We accept all major insurance carriers. If you do not have insurance, please contact our in-house billing department to discuss alternative payment options.

It is the patient's responsibility to inform our office of any changes in insurance coverage. Failure to do so may cause delay or denial of insurance payment. If your insurance company does not pay for your charges, the balance becomes the patient's responsibility.

Patients are responsible for co-payments, co-insurance, and deductibles at the time of service. If we are unable to verify insurance coverage prior to your scheduled appointment, the patient may be responsible for the cost of the office visit at the time of service.

Payments

Ascent Cardiovascular Center accepts cash, personal checks, and most major credit cards. Payments can be mailed to Ascent Cardiovascular Center at 602 S Audubon Avenue, Suite B, Tampa, FL, 33609. Patients can also make credit card payments over the telephone by contacting Ascent Cardiovascular Center directly at (813) 540-4322.

Forms & Fees

Per HIPAA guidelines, copies of medical records must be requested in writing. To ensure your privacy, a form for release of medical information must be completed prior to release of these materials. Any medical records that are requested by another physician's office will be faxed directly to that office at no fee. Medical records requested by other parties, such as insurance companies or attorney's offices will be subject to fees. You will not be charged for physician letters, nursing home forms, or other forms required by State or Federal Government Agencies. Patients will be charged as followed for completion or production of the following forms and documents:

- Patients: $25.00
- FMLA, Disability, and Employment Forms: $25.00
- Attorney's Offices & other entities: $50.00 and up depending on the number of pages.

Turnaround time for completion of forms is typically 5 to 7 days. However, please allow up to two weeks for your forms to be processed.

Collection Agency

Depending on the circumstance Ascent Cardiovascular Center may use an outside collection agency for financial recovery when necessary. An administrative fee of 30% will be assessed to your account along with the fees assessed by the collection agency to recover any financial loses.

HIPAA Compliance Patient Consent Form

Patient Name:_____ **Date of Birth:** _____

HIPAA is an acronym for the Health Insurance Portability & Accountability Act of 1996 (a Federal Law).

Of significant concern to healthcare organizations is the Administrative Simplification section of the Act, which requires healthcare organizations to comply with specific rules regarding:

- Unique identifiers for health plan, providers, individuals and employers
- Healthcare Transaction & Code Sets for transmitting data electronically
- Privacy regulations over disclosure and use of health information
- Security regulations over protections of electronic health information

It is our policy to not release confidential and/or unauthorized information by telephone, answering machine voicemail, and/or email (with the exception of appointment reminders that reveal doctor's name date and time only). In the instance when we are returning a phone call and have to leave a message with an unauthorized person no information will be left.

If you wish to authorize us to leave and/or release information with someone other than yourself please list the authorized person(s) below:

Name: _____ **Relation:** _____ **Phone:** _____

Name: _____ **Relation:** _____ **Phone:** _____

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

I understand that as part of my healthcare, Ascent Cardiovascular Center originates and maintains health records describing my health history, symptoms, examinations and test results, diagnosis, treatment and any plans for future care or treatment. I understand that this information serves as:

- A basis for planning my care and treatment
- A means of communications among the many healthcare professionals involving 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 receiving the competence of healthcare professionals

Special Situations: We may release medical information about you for worker's compensation or similar programs. These programs provide benefits for work related injuries or illness. We may disclose medical information about you for public health activities such as to prevent or control disease, injury, disability and driving, etc.

This Notice describes how information about you may be used and disclosed and how you can gain access to this information. Please review it carefully.

Notice of Information Practices

Ascent Cardiovascular Center may use and disclose protected health information for treatment, payment and healthcare operations, health related benefits and services, release of information to designated individual entities, and disclosures required by the law. Examples of this include, but are not limited to: requested life insurance, sports physicals, referral to nursing homes, foster care homes, home health agencies and/or referral to other providers for treatment to include coordination of benefits with other insurers, or collection agencies. Healthcare operations include, but are not limited to, internal quality control, quality assurance and auditing of records.

Ascent Cardiovascular Center is permitted or required to use or disclose protected health information without the individual's written consent or authorization in certain circumstances. These circumstances include, but are not limited to, cases of public health requirements or court orders.

Ascent Cardiovascular Center will not make any other use or disclosure of a patient's protected health information without the individual's written authorization. The individual may revoke such authorization at any time. Any revocation of authorization must be submitted in writing.

Ascent Cardiovascular Center may, at times, contact the patient to provide appointment reminders, information regarding treatment alternatives or other health related benefits and services that may be of interest to the individual patient or the concern of the Physician.

Ascent Cardiovascular Center will abide by the terms of this notice, or the notice currently in effect at the time of disclosure.

Ascent Cardiovascular Center reserves the right to change the terms of this notice and make new notice provisions effective for all protected health information it maintains.

Ascent Cardiovascular Center will provide each patient with a copy of any revisions to the Notice of Information Practices at the time of their next visit, if requested, or at their last known address, if there is a need to use or disclose any protected health information of the patient. Copies may also be obtained at any time at our office.

Any person/patient may file a complaint to the Practice and to the Secretary of Health and Human Services if they believe their privacy rights have been violated. To file a complaint with the Practice please contact the Privacy Officer and/or the HIPAA Officer at the address and phone number listed below. All complaints will be addressed and the results reported to the Owner/Managing Physician.

Ascent Cardiovascular Center
602 S Audubon Ave
Suite B
Tampa, FL 33609

Receipt Acknowledgment Form

By signing below, I acknowledge that I have received, reviewed, understand, and will comply with the policies and procedures explained in the Ascent Cardiovascular Center Policies and Procedures and HIPAA patient forms.

Printed Name of Patient

Signed Name **Date**

HIPAA Receipt Acknowledgment

I understand and have been provided with a Notice of Information Practice that provides a more complete description of information uses and disclosures. I understand that I have the right to review the notice prior to signing this consent. I understand that the Practice reserves the right to change their notice and practices. I understand that I have the right to object to use of my health information for direct purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment or healthcare operations and that the Practice 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 Practice has already taken action in reliance thereon.

Patient/Guardian Signature **Date**

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Consent for Communication via E-mail

I,

Last Name: _____ **First Name:** _____

Email address: _____

, hereby consent to have my providers at Ascent Cardiovascular Center communicate with me or members of the staff, where appropriate, or other physicians, nurse practitioners, and physician assistants via email regarding the following aspects of my medical care and treatment: appointments and scheduling, billing, prescriptions, test results, etc. I understand that email is not a confidential method of communication. I further understand that there is a risk that email communications between my providers and me or member's of my provider's office staff regarding my medical care and treatment may be intercepted by third parties or transmitted to unintended parties. I also understand that any email communications between my provider and me or member's of my provider's office staff will be stored and become a part of my medical record. I understand that in an urgent or emergent situation I should call my provider, call 911, or go to the nearest Emergency Department and not rely on email.

Patient Name: _____

Patient Signature: _____

Today's Date: _____

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Consent for Communication via Text Message (SMS)

By signing below, I authorize Ascent Cardiovascular Center to contact me by SMS text message for health-related notifications, including appointment reminders and billing communications. I understand that message/data rates may apply to messages sent under my cell phone plan. I know that I am under no obligation to authorize Ascent Cardiovascular Center to send me text messages. I may opt-out of receiving these communications at any time. I understand that text messages are not a substitute for professional or medical attention. By signing below, I indicate I am the person legally responsible for all use of mobile accounts, that I am at least 18 years of age, and that I agree to all terms and conditions of use for the text messaging services.

Please mark the following:

☐ I consent to receiving information via text. I understand I can withdraw my consent at any time. Text Cell #_____

☐ I do not consent to receiving any information via text. I understand that I can change my mind and provide consent later.

Patient Name: _____

Patient Signature: _____

Today's Date: _____

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Authorization to Obtain, Release or Review Protected Health Information

I, _____,
Print Name Date of Birth Social Security #

hereby authorize **Ascent Cardiovascular Center**

Please check one:

☐ To obtain from Dr. _____

☐ To release to Dr. _____

☐ To release to me (enter your home address below)

_____
Name of Doctor/Provider Phone Number

_____
Address Fax Number

- ☐ All medical information and reports
- ☐ Physical examination reports
- ☐ Laboratory reports
- ☐ Immunization reports
- ☐ Sexually transmitted infection reports
- ☐ Psychiatric/Psychological reports
- ☐ HIV/AIDS test results
- ☐ Genetic testing and information
- ☐ Other (please specify) _____

Please specify anything you do NOT want to be released:

_____

I understand that this authorization extends to all or any part of the records designated above, which may include psychiatric information, and/or genetic counseling/testing, and/or alcohol/drug abuse and/or HIV/AIDS test results. I expressly consent to the release of information as designated above.

I understand this authorization will remain in effect for one year unless otherwise specified. I understand that this authorization is revocable upon written notice to the office where the original authorization is retained. I understand that my protected health information that is used or disclosed under this authorization may be subject to re-disclosure by the recipient and the privacy of my protected health information may no longer be protected by law. I also understand that payment, enrollment in a health plan and/or eligibility for benefits will not be conditioned upon my signing this form. I understand that I may refuse to sign this form. I understand that after signing this form, there is a processing period of 7–10 business days.

_____
Patient/Legal Representative or Parent/Legal Guardian **Date**