San Diego Cardiovascular Associates

PATIENT CONSENT TO OBTAIN/DISCLOSURE OF PRIVATE HEALTH INFORMATION FOR TREATMENT, PAYMENT OR HEALTHCARE OPERATIONS

La Jolla Office ♥ 9850 Genesee Ave., Suite 780♥ La Jolla, CA. 92037
Encinitas Office ♥ 320 Santa Fe Dr., Suite 204 ♥ Encinitas, CA. 92024

I hereby authorize ***San Diego Cardiovascular Associates*** to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past. This would include receiving these records via fax, e-mail and/or internet.

I understand that as part of my health care ***San Diego Cardiovascular Associates*** originates and maintains paper and/or electronic medical records describing my health history, symptoms, examinations and test results, diagnoses, treatment and any plans for future care or treatment.

I understand that as a part of ***San Diego Cardiovascular Associates*** treatment, billing, or health care operations, it may become necessary to disclose my protected health information to referring physicians, hospitals, and any insurance company, third party administrator, or managed care company. This would include disclosures via fax, e-mail and/or internet.

I understand that this information serves as:

A basis for planning my medical treatment and communication among health professionals who contribute to my care, a source of information for applying my diagnosis and surgical information to my bill, to verify services billed were actually provided, a tool for routine healthcare operations such as assessing quality and reviewing the competence of healthcare professionals.

_____ _____

Patient Signature Date

_____ _____

Printed Name Date of Birth