PINEYWOODS HEART

CONSENT AND AUTHORIZATION FORM

Consent To Medical Treatment

I hereby voluntarily consent to receive medical treatment and diagnostic procedures from my physician, her assistants or her consignees as may be necessary in her judgement. I acknowledge that no guarantees have been made as to the result of treatments or examinations in clinic.
This form has been fully explained to me and I certify that I understand its contents.

_____	_____	_____
Patient Name	Patient Signature	Date

Witness _____

IF PATIENT IS A MINOR OR UNABLE TO PROVIDE CONSENT PLEASE INFORM STAFF TO EXECUTE A SEPARATE FORM.

Notice of Privacy Practices

A Notice of Privacy Practices (NPP) is provided to all patients. This Notice of Privacy Practices identifies: 1) how medical information about you may be used or disclosed; 2) your rights to access your medical information, amend your medical information, request an accounting of disclosures of your medical information, and request additional restrictions on our uses and disclosures of that information; 3) your rights to complain if you believe your privacy rights have been violated; and 4) our responsibilities for maintaining the privacy of your medical information.

I also authorize the release of my medical information, including protected health information, to the following person(s):

_____	_____
Name	Relationship to Patient
_____	_____
Name	Relationship to Patient

I certify that I have read the above, received a copy of the Notice of Privacy Practices and I am the patient:

_____	_____	_____
Patient Name	Patient Signature	Date

Financial Policy

I have been given a copy of the financial policy and I agree to be bound by its terms. I also understand and agree that such terms may be amended by the practice from time to time.

_____	_____	_____
Patient Name	Patient Signature	Date