

EKG Consent Form

Suwannee Oaks Medical
112 Irvin Ave. SW Live Oak, Fl. 32064
Phone: (386) 339-6380 | Fax: (386) 330-0303

Consent for Purpose of Treatment, Payment, Health Care Operations and Notice of Privacy Practices

I consent to the use or disclosure of my protected health information by Suwannee Oaks Medical, for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct health care operations. I understand that diagnosis or treatment of me by Aymee Wilson, APRN and Cheryl Abersold, APRN may be conditioned upon my consent as evidenced by my signature on this document.

I understand I have the right to request a restriction as to how my protected health information is used or disclosed to carry out treatment, payment or healthcare operations of the practice. Suwannee Oaks Medical is not required to agree to the restrictions that I may request. However, if Suwannee Oaks Medical agrees to a restriction that I request, the restriction is binding between Suwannee Oaks Medical and

(Write patient's name here)

I have the right to revoke this consent, in writing, at any time, except to the extent that Aymee Wilson, APRN and Cheryl Abersold, APRN or Suwannee Oaks Medical have taken action in reliance on the consent.

My "Protected Health Information" means health information, including my demographic information, collected from me and created or received by my physician, another health care provider, a health plan, my employer or a health care clearinghouse. This protected health information relates to my past, present, or future physical or mental health or condition and identifies me or there is a reasonable basis to believe the information may identify me.

I understand I have a right to review Suwannee Oaks Medical's Notice of Privacy Practices prior to signing this document. The Notice of Privacy Practices is available to me. The Notice of Privacy Practices describes the types of uses and disclosures of my protected health information that will occur in my treatment, payment of my medical claims or in the performance of health care operations of Suwannee Oaks Medical. The Notice of Privacy Practices for Suwannee Oaks Medical is also available at the front desk of the clinic. This Notice of Privacy Practices also describes my rights and the Suwannee Oaks Medical duties with respect to my protected health information.

Suwannee Oaks Medical reserves the right to change the privacy practices described in the Notice of Privacy Practices. I may obtain a revised Notice of Privacy Practices by calling the office and requesting a revised copy be sent in the mail or asking for one at the time of my next appointment.

Patient Name: _____ **DOB:** _____ **Contact Number:** _____

Signature of Patient or Personal Representative's Authority

Print Name of Patient or Personal Representative's Authority

Description of Personal Representative's Authority

Date