

# Georgia Heart & Vascular Center, P.C.

## Release of Information

Georgia Heart & Vascular Center, P.C. is committed to protecting the privacy of our patients. Therefore, we will not give test results, medical information, financial information or other private health information to anyone other than the patient, guardian, or referring doctor, nor leave messages about test results on voicemail or an answering machine without your permission.

Please indicate your preferences below:

**You may contact me at the phone number(s) listed below with test results. *If no numbers are listed we will only call the home number listed in our records.***

\_\_\_\_\_  
\_\_\_\_\_

**Yes No You may leave a message on my answering machine or voice mail**

**Yes No You may provide private health information about me (or the patient) as indicated below (information will be provided only to those listed):**

| <u>Name</u> | <u>Relationship</u> | <u>Information to provide</u>    |                                    |
|-------------|---------------------|----------------------------------|------------------------------------|
| _____       |                     | <input type="checkbox"/> Medical | <input type="checkbox"/> Financial |
| _____       |                     | <input type="checkbox"/> Medical | <input type="checkbox"/> Financial |
| _____       |                     | <input type="checkbox"/> Medical | <input type="checkbox"/> Financial |
| _____       |                     | <input type="checkbox"/> Medical | <input type="checkbox"/> Financial |
| _____       |                     | <input type="checkbox"/> Medical | <input type="checkbox"/> Financial |

*Under HIPAA regulations we may provide private health information to other healthcare entities involved in your care and insurance companies for billing purposes without your permission.*

**By signing this form, I understand that the information provided above supersedes all previous notifications and will remain in force until I provide different written instructions.**

**Patient or guardian signature** \_\_\_\_\_ **Date signed** \_\_\_\_\_

**Printed patient name** \_\_\_\_\_

**Relationship of guardian (if applicable)** \_\_\_\_\_