

**Patient Consent Form**

By signing this form, you are granting consent to (Cardiovascular Assoc. of RI, Inc.) to use and disclose your protected health information for the purposes of treatment, payment and health care operations. Our Notice of Privacy Practices provides more detailed information about how we may use and disclose this protected health information. You have a legal right to review our Notice of Privacy Practices before you sign this consent, and we encourage you to read it in full.

Our Notice of Privacy Practices is subject to change. If we change our notice, you may obtain a copy of the revised notice by: contacting us at 401-273-2460.

You have a right to request us to restrict how we use and disclose your protected health information for the purposes of treatment, payment or health care operations. We are not required by law to grant your request. However, if we do decide to grant your request, we are bound by our agreement.

You have the right to revoke this consent in writing, except to the extent we already have used or disclosed your protected health information in reliance on your consent.

Signature: \_\_\_\_\_

Date: \_\_\_\_\_

Please list any specific people or physicians/laboratories/testing facilities, etc., that you authorize us to release information to. (If you wish to authorize your Cardiologist at this facility to speak directly to a family member regarding your medical information, they should be listed below. This will serve as your written authorization to release information to that specific individual).

NAME:

RELATIONSHIP:

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