HIPAA Consent Form

The Health Insurance Portability and Accountability Act (HIPAA) is a federal government regulation designed to ensure that you are aware of your privacy rights and of how your medical information can be used by our staff in providing care arranging your medical care. Heart Rhythm Specialists is committed to securing the privacy of your health information. We are supplying you with a copy of our Notice of Privacy Practices. You are not required to read this notice. By initialing, you are acknowledging receipt of this notice.

I, ___________________________________, give permission to Heart Rhythm Specialists and associated health care and medical services providers and payers to disclose and release my protected health information to the following:

Name	Relationship	Phone Number
_________________________________	_______________________	_(______)_______________
_________________________________	_______________________	_(______)_______________
_________________________________	_______________________	_(______)_______________
_________________________________	_______________________	_(______)_______________

This health information may be used to enable the persons I authorize to know and understand my condition and my treatment or treatment options, for treatment or consultation, for claims payment purposes, or related reasons.

The authorization shall be effective until I give written consent to revoke it.

Signature of patient or personal representative: ____

Printed name of patient or personal representative: ____

Relationship to patient:_________________________________Date: ____________________________

Patient Contact Form

I, ____________________________________, give permission for employees of Heart Rhythm Specialists to contact me at the following methods regarding my private health information. By providing my phone number, I consent to receive SMS text messages from Heart Rhythm Specialists for appointment reminders, marketing messages, and general two-way communication. Message frequency may vary. Message and data rates may apply. Reply HELP for support or STOP to opt out. Please refer to our privacy policy and terms and conditions.

Method	Number/Address	Okay to leave message? (Circle One)
Home Phone		YES / NO
Cell Phone		YES / NO
Work Phone		YES / NO
Text Message		YES / NO
Email		YES / NO
Athena Portal		YES / NO

Signature of patient or personal representative: ____________________________________

Printed name of patient or personal representative: ____________________________________

Relationship to patient:_____________________________Date: __________________________