Why *MyChart*?

MyChart gives you direct, online access to portions of your electronic healthcare record where your doctor stores your healthcare information. Your lab results, appointment information, medications, immunizations and more are all securely stored for quick access.

MyChart also provides easy, convenient methods for communicating with your doctor's office. Renew prescriptions, send messages, and schedule appointments - all online.

Your St. David's Heart & Vascular staff can tell you more about ***MyChart*** and help you sign up.

Your healthcare, with *MyChart*

Be an informed patient. Your healthcare is important, and asking the right questions helps you and your doctor manage your healthcare and decide on appropriate plans for your good health.

Find out how ***MyChart*** can help you stay in touch with your doctor.

For more information, or to sign up, talk to us here or visit our website listed below.

MyChart is available as an App for iPhone, iPad and Android devices. Visit the App store to download. Keyword - MyChart.

Visit us at:
https://MyChart.StDavids.com

St David's Heart & Vascular

St David's Heart & Vascular

MyChart

Your Secure Online Health Connection

Access your own, personal medical records in your own home or wherever you have Internet connection

FAQs

Is my information safe?

Yes. Our team of security experts has created a secure, encrypted connection for your ***MyChart*** site. Your security is important, and we take your security seriously.

How do I sign up?

Ask the staff at St. David's Heart & Vascular. You can also do it yourself by logging into our website at: https://MyChart.stdavids.com to complete the process online. You can also scan the QR code on the front of this brochure to visit the ***MyChart*** site.

What if I forget my user name or password?

Don't worry. Just click the "Forgot Password" link and follow the online instructions.

Can I update my information in MyChart?

There is some information you can change, such as medications you're currently taking, immunizations you received somewhere else, allergies and medical history. Your changes will be sent to your doctor for approval. There is some information that only your doctor can update. Consult your doctor if you see something that is incorrect.

Can I access MyChart on my smartphone or tablet?

Yes. Download the ***MyChart*** mobile app by visiting the app store and downloading the ***MyChart*** mobile app.

See what your doctor sees.

View your medical information online

- Review your current medications, immunizations, allergies, and medical history.
- Receive test results online - as soon as your doctor releases the results - no waiting for a phone call or letter.
- Review discharge instructions provided by your doctor.
- Review health education topics.

Manage your appointments

- Review past and upcoming appointments.
- Request, change or cancel appointments.
- Complete information online prior to your next visit. For example, complete your history, or report medication changes before your visit - all online in the privacy of your home.

Access your family's records

- Link your family's accounts to yours for convenient access to appointments, immunization records, growth charts, or information concerning your elderly parent.

Information about your procedures

- You see information on your labs, imaging tests, discharge instructions from your hospital stay.

hCare® | Epic

HCA© MyChart-Austin revised 04/03/2014

Stay in touch with your doctor

- Getting in touch with your doctor is as easy as sending an email - but more secure!
- Request medication renewals online.

SECURITY...

IS MY INFORMATION SECURE???

Yes. Your information is safe from unauthorized access because MyChart is password protected and delivered through an encrypted connection.

St David's Heart & Vascular

Patient Registration Form

(Please print or write legibly)

Last Name:_____First:_____MI:_____

Gender Identity: ☐ Female ☐ Male ☐ Transgender Female to Male ☐ Transgender Male to Female ☐ Choose not to disclose

Date of Birth:_____Social Security:_____

Mailing Address:_____ Apt. #:_____

City:_____ State:_____ Zip:_____

Please check the preferred primary phone number:

☐ Home Phone: (_____)-_____ ☐ Work Phone: (_____)-_____

☐ Mobile Phone: (_____)-_____Email:_____

Preferred Language:_____ Marital Status:_____ Race/Ethnicity:_____

Emergency Contact Person:_____ Relationship: _____

Primary Number: (_____)-_____ Secondary Number: (_____)-_____

Primary Care Physician:_____ Referring Physician:_____

Employer's Name:_____ Occupation:_____

Employer's Mailing Address:_____ Suite #:_____

City:_____ State:_____ Zip:_____

Insurance

Insurance card(s) or proof of insurance must be presented at time of service.

Primary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: ____/____/_____

Secondary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: ____/____/_____

Tertiary Insurance: _____Policy #_____

Policy Holder's Name:_____Policy Holder's Date of Birth: ____/____/_____

Assignment and Authorization of Benefits for Patients with Insurance

I hereby assign all medical and /or surgical benefits, to which I am entitled, including Medicare, private insurance, and other plans to St. David's Heart & Vascular, PLLC. I understand that I am financially responsible for all charges, co-payments, co-insurance and deductibles. To the extent necessary to determine liability for payment and to obtain reimbursement, I authorize disclosure of portions of the patient's medical record. I authorize insurance claims filed and benefits assigned.

_____ _____

Signature of Patient or Personal Representative **Date**

Financial acknowledgement for Private Pay Patients or Patients without Insurance

Patients who do not have insurance coverage are expected to pay charges in full at the time services are rendered. I agree that I am financially responsible for all charges incurred during the time of service.

_____ _____

Signature of Patient or Personal Representative **Date**

St David's Heart & Vascular

PATIENT CONSENT FORM

General Consent for Care and Treatment Consent

TO THE PATIENT: You have the right, as a patient, to be informed about your condition and the recommended surgical, medical, or diagnostic procedure to be used so that you may make the decision whether or not to undergo any suggested treatment or procedure after knowing the risks and hazards involved. At this point in your care, no specific treatment plan has been recommended. This consent form is simply an effort to obtain your permission to perform the evaluation necessary to identify the appropriate treatment and/or procedure for any identified condition(s). The consent will remain fully effective until it is revoked in writing.

This consent provides us with your permission to perform reasonable and necessary medical examinations, testing and treatment. By signing below, you are indicating that (1) you intend that this consent is continuing in nature even after a specific diagnosis has been made and treatment recommended; and (2) you consent to treatment at this office or any other satellite office under common ownership.

You have the right to discuss the treatment plan with your physician about the purpose, potential risks and benefits of any test ordered for you. If you have any concerns regarding any test or treatment recommend by your health care provider, we encourage you to ask questions. You have the right at any time to discontinue services.

I voluntarily request a St. David's Heart and Vascular physician, and/or mid-level provider (Nurse Practitioner, Physician Assistant, or Clinical Nurse Specialist), and other health care providers or the designees as deemed necessary, to perform reasonable and necessary medical examination, testing and treatment for the condition which has brought me to seek care at St. David's Heart & Vascular, PLLC. I understand that if additional testing, invasive or interventional procedures are recommended, I will be asked to read and sign additional consent forms prior to the test(s) or procedure(s).

I certify that I have read and fully understand the above statements and consent fully and voluntarily to its contents.

Signature of Patient or Personal Representative	**Date**
Printed Name of Patient or Personal Representative	**Relationship to Patient**
Printed Name of Witnessing Employee	**Employee Job Title**
Signature of Witnessing Employee	Date

Web Shared Services
Patient HIPAA Acknowledgement and Consent Form

Patient Last Name	Patient First Name (Printed)	MI	Date of Birth (MM/DD/YYYY)

Notice of Privacy Practices/clinics.

- _____ **(Patient/Representative initials)** I acknowledge that I have received the practice/clinic's Notice of Privacy Practice/clinics, which describes the ways in which the practice/clinic may use and disclose my healthcare information for its treatment, payment, healthcare operations and other described and permitted uses and disclosures, I understand that I may contact the Privacy Officer designated on the notice if I have a question or complaint. I understand that this information may be disclosed electronically by the Provider and/or the Provider's business associates. To the extent permitted by law, I consent to the use and disclosure of my information for the purposes described in the practice/clinic's Notice of Privacy Practice/clinics.

Disclosures to Friends and/or Family Members

DO YOU WANT TO DESIGNATE A FAMILY MEMBER OR OTHER INDIVIDUAL WITH WHOM THE PROVIDER MAY DISCUSS YOUR MEDICAL CONDITION? IF YES, WHOM?I give permission for my Protected Health Information to be disclosed for purposes of communicating results, findings and care decisions to the family members and others listed below:

	Name	Relationship	Contact Number
1.			
2.			
3.			

Patient/Representative may revoke or modify this specific authorization and that revocation or modification must be in writing.

Communication about My Healthcare

I agree the Provider or an agent of the Provider or an independent physician's office may contact me for the purposes of scheduling necessary follow-up visits recommended by the treating physician.

Consent for Photographing or Other Recording for Security and/or Health Care Operations

I consent to photographs, digital or audio recordings, and/or images of me being recorded for patient care, security purposes and/or the practice's/clinic's health care operations purposes (e.g., quality improvement activities). I understand that the practice/clinic retains the ownership rights to the images and/or recordings.

I will be allowed to request access to or copies of the images and/or recordings when technologically feasible unless otherwise prohibited by law. I understand that these images and/or recordings will be securely stored and protected. Images and/or recordings in which I am identified will not be released and/or used outside the facility without a specific written authorization from me or my legal representative unless otherwise permitted or required by law.

Consent to Email, Cellular Telephone, or Text Usage for Appointment Reminders and Other Healthcare Communications:

If at any time I provide an email address or cellphone number at which I may be contacted, I consent to receiving unsecure instructions and other healthcare communications at the email or text address I have provided or you or your EBO Servicer have obtained, at any text number forwarded, or transferred from that number. These instructions may include, but not be limited to: post-procedure instructions, follow-up instructions, educational information, and prescription information. Other healthcare communications may include, but are not limited to, communications to family or designated representatives regarding my treatment or condition, or reminder messages to me regarding appointments for medical care. Note: You may opt out of these communications at any time. The practice/clinic does not charge for this service, but standard text messaging rates or cellular telephone minutes may apply as provided in your wireless plan (contact your carrier for pricing plans and details).

Note: This clinic uses an Electronic Health Record that will update all your demographics and consents to the information that you just provided. Please note this information will also be updated for your convenience to all our affiliated clinics that share an electronic health record in which you have a relationship.

Release of Information.

I hereby permit practice/clinic and the physicians or other health professionals involved in the inpatient or outpatient care to release healthcare information for purposes of treatment, payment, or healthcare operations.

- Healthcare information regarding a prior service(s) at other HCA affiliated providers may be made available to subsequent HCA-affiliated providers to coordinate care. Healthcare information may be released to any person or entity liable for payment on the Patient's behalf in order to verify coverage or payment questions, or for any other purpose related to benefit payment. Healthcare information may also be released to my employer's designee when the services delivered are related to a claim under worker's compensation.
- If I am covered by Medicare or Medicaid, I authorize the release of healthcare information to the Social Security Administration or its intermediaries or carriers for payment of a Medicare claim or to the appropriate state agency for payment of a Medicaid claim. This information may include, without limitation, history and physical, emergency records, laboratory reports, operative reports, physician progress notes, nurse's notes, consultations, psychological and/or psychiatric reports, drug and alcohol treatment and discharge summary.
- Federal and state laws may permit this facility to participate in organizations with other healthcare providers, insurers, and/or other health care industry participants and their subcontractors in order for these individuals and entities to share my health information with one another to accomplish goals

that may include but not be limited to: improving the accuracy and increasing the availability of my health records; decreasing the time needed to access my information; aggregating and comparing my information for quality improvement purposes; and such other purposes as may be permitted by law. I understand that this facility may be a member of one or more such organizations. This consent specifically includes information concerning psychological conditions, psychiatric conditions, intellectual disability conditions, genetic information, chemical dependency conditions and/or infectious diseases including, but not limited to, blood borne diseases, such as HIV and AIDS.

I certify that I have read and fully understand the above statements from all pages and consent fully and voluntarily to its contents.

Patient/Representative Signature	Relationship to Patient (self, parent, legal guardian/representative, etc)	Date

Prescription Order Pick-up. There may be times when you need a friend or family member to pick-up a prescription order (script) from your physician's office. In order for us to release a prescription to your family member or friend, we will need to have a record of their name. Prior to release of the script, your designee will need to present valid picture identification and sign for the prescription.

- I do want _____ (Patient/Representative Initials) to designate the following individual to pick up a prescription order on my behalf:

Name	Relationship

- I do not want _____ (Patient/Representative Initials) to designate anyone to pick-up my prescription order.

Print

Updated: October 8, 2018 v7 replacing 1/05/2018, 12/20/2016, 04/22/2016, 10/28/2015, 06/12/2015, 11/21/2013
A photocopy of this consent shall be considered as valid as the original.

St David's Heart & Vascular

MEDICAL HISTORY QUESTIONNAIRE

IF IT HAS BEEN THREE OR MORE YEARS SINCE YOUR LAST VISIT, COMPLETE THE ENTIRE FORM
IF LESS THAN THREE YEARS, PLEASE UPDATE AREAS THAT HAVE CHANGED SINCE THE LAST VISIT

Patient Name_____Appt. Date_____ Date of Birth_____ Age_____

Gender ◯Female ◯Male Primary Care Doctor_____

DO YOU HAVE A LIVING WILL OR A MEDICAL POWER OF ATTORNEY? ◯ **YES** ◯ **NO**
HAVE YOU HAD THIS SEASON'S FLU IMMUNIZATION ◯ **YES** ◯ **NO** **DATE**_____
HAVE YOU HAD YOUR PNEUMONIA IMMUNIZATION ◯ **YES** ◯ **NO** **DATE**_____

Please check anything you have been diagnosed with:

PAST MEDICAL HISTORY

- ◯ Aortic aneurysm
- ◯ A-Fib
- ◯ Anemia
- ◯ Angina
- ◯ Arrhythmia
- ◯ Asthma
- ◯ Cancer
- ◯ Cardiomyopathy
- ◯ Heart Failure
- ◯ Clotting disorder
- ◯ Coronary artery disease
- ◯ Diabetes
- ◯ Heart murmur
- ◯ High cholesterol
- ◯ High blood pressure
- ◯ Kidney disease
- ◯ Heart attack
- ◯ Peripheral arterial disease
- ◯ Sleep apnea
- ◯ Stroke/TIA
- ◯ Syncope (fainting)
- ◯ Thyroid disease
- ◯ Varicose/Spider Veins

OTHER MEDICAL HISTORY

- ◯ Anxiety
- ◯ Arthritis
- ◯ Blood clots in veins/lungs
- ◯ COPD/Emphysema
- ◯ Depression
- ◯ Easy bruising/bleeding
- ◯ HIV/AIDS
- ◯ Liver problems/Hepatitis
- ◯ Menopause
- ◯ _____
- ◯ Phlebitis/Swelling
- ◯ Rheumatic fever
- ◯ Stomach/Intestinal ulcers
- ◯ Tuberculosis
- ◯ _____

PAST CARDIAC SURGERIES

- ◯ AAA repair
- ◯ Cardiac ablation
- ◯ ASD repair
- ◯ Coronary bypass
- ◯ Cardiac catheterization
- ◯ Carotid disease
- ◯ Cardioversion
- ◯ Carotid stent
- ◯ Coronary stent
- ◯ ICD
- ◯ _____
- ◯ LARIAT
- ◯ Pacemaker
- ◯ Peripheral stent
- ◯ Valve repair/replacement
- ◯ _____

OTHER SURGICAL HISTORY

- ○ Appendectomy
- ○ Carpal tunnel release
- ○ Cataract
- ○ C-section
- ○ _____
- ○ Fracture repair
- ○ Gall bladder
- ○ Hip replacement
- ○ Hysterectomy
- ○ _____
- ○ Knee replacement
- ○ Knee surgery
- ○ Tonsils/Adenoids
- ○ Vasectomy/Tubal ligation
- ○ _____

FAMILY HISTORY

Relationship	*Alive/Deceased*	*Arrhythmia*	*Coronary artery disease*	*Clotting disorder*	*Diabetes*	*Heart attack*	*Heart disease*	*Heart failure*	*High cholesterol*	*High blood pressure*	*Stroke/TIA*	*Sudden cardiac death*	*Varicose veins*	*Venous insufficiency*
Mother														
Father														
Sister														
Brother														
Mat Aunt														
Mat Uncle														
Pat Aunt														
Pat Uncle														
MGM														
MGF														
PGM														
PGF														

☐ Adopted ☐ Family History Unknown

SOCIAL HISTORY

Do you drink alcoholic beverages? ◯ Yes ◯ No

How many drinks per week? ____ glasses of wine
____ cans of beer
____ shots of liquor
____ mixed drinks

Do you use illegal drugs/abuse prescription drugs? ◯ Yes ◯ No If yes which drugs? _____
How often? _____

Have you ever been a smoker? ◯ Never ◯ Former, quit date _____ ◯ Current smoker
Years smoked _____ Packs per day _____

Do you use smokeless tobacco? ◯ Never ◯ Former, quit date _____ ◯ Current user
Years used _____ Uses per day _____

If you smoke/use tobacco, are you ready to quit? ◯ Yes ◯ No

Do you exercise regularly? ◯ Yes ◯ No

Do you drink caffeine? ◯ Yes ◯ No

ALLERGIES

Have you had a reaction to X-Ray contrast dye? ◯ Yes ◯ No

Are you allergic to iodine or shellfish? ◯ Yes ◯ No

Are you allergic to any medications? ◯ Yes ◯ No

If yes, please list medication names_____

St David's Heart & Vascular

Medication List

Patient Name:_____ Date of Birth:_____

Pharmacy:_____ Address/Location:_____ Phone number:_____

Please include all prescription and over-the-counter medications, including herbal products and vitamins. **Please update the form before every physician visit and bring the form to every visit.**

	Medication	Dose	How Often
example	*Metoprolol tartrate*	*25 mg*	*Twice daily*
1			
2			
3			
4			
5			
6			
7			
8			
9			
10			
11			
12			
13			
14			
15			
16			
17			
18			
19			
20			

St David's Heart & Vascular

REVIEW OF CLINICAL SYSTEMS

Please check all that apply

General
- ☐ Loss of appetite
- ☐ Chills
- ☐ Fever
- ☐ Generalized weakness
- ☐ Malaise/Fatigue
- ☐ Night sweats
- ☐ Weight gain
- ☐ Weight loss

Eyes
- ☐ Blurred vision
- ☐ Double vision
- ☐ Vision loss

Respiratory
- ☐ Cough
- ☐ Coughing up blood
- ☐ Shortness of breath
- ☐ Sleep disturbances due to breathing
- ☐ Snoring
- ☐ Wheezing
- ☐ C-Pap

Skin
- ☐ Flushing
- ☐ Poor wound healing
- ☐ Rash

Ears/Nose/Throat
- ☐ Congestion
- ☐ Headaches
- ☐ Hearing loss
- ☐ Hoarseness
- ☐ Nosebleeds
- ☐ Sore throat
- ☐ Ringing in ears

Cardiovascular
- ☐ Chest Pain
- ☐ Leg pain with walking
- ☐ Bluish tint to skin
- ☐ Difficulty breathing on exertion
- ☐ Irregular heartbeats
- ☐ Leg swelling
- ☐ Light-headedness
- ☐ Short of breath when lying flat
- ☐ Palpitations
- ☐ Waking up short of breath
- ☐ Fainting

Endocrine
- ☐ Intolerance of cold
- ☐ Intolerance of heat
- ☐ Excessive thirst
- ☐ Excessive hunger
- ☐ Excessive urinating

Hematology
- ☐ Bleeding
- ☐ Easy bruising/bleeding

Musculoskeletal
- ☐ Back pain
- ☐ Falls
- ☐ Joint pain
- ☐ Joint swelling
- ☐ Muscle cramps
- ☐ Muscle weakness

Gastrointestinal
- ☐ Abdominal bloating
- ☐ Abdominal pain
- ☐ Anorexia
- ☐ Change in bowel habits
- ☐ Bowel incontinence
- ☐ Constipation
- ☐ Diarrhea
- ☐ Difficulty swallowing
- ☐ Heartburn
- ☐ Vomiting blood
- ☐ Bright red blood in stool
- ☐ Hemorrhoids
- ☐ Jaundice
- ☐ Black tarry stools
- ☐ Nausea
- ☐ Vomiting

Genitourinary
- ☐ Bladder incontinence
- ☐ Decreased libido
- ☐ Painful urination
- ☐ Flank pain
- ☐ Frequent urination
- ☐ Blood in urine
- ☐ Hesitancy when urinating
- ☐ Incomplete emptying of bladder
- ☐ Excessive urination at night
- ☐ Urinary urgency

Neurological
- ☐ Brief paralysis
- ☐ Concentration difficulty
- ☐ Coordination disturbances
- ☐ Daytime sleepiness
- ☐ Dizziness
- ☐ Weakness in one region of body
- ☐ Light-headedness
- ☐ Loss of balance
- ☐ Numbness
- ☐ Seizures
- ☐ Sensory change
- ☐ Tremors

Psychiatric
- ☐ Altered mental status
- ☐ Depression
- ☐ Hallucinations
- ☐ Insomnia
- ☐ Memory loss
- ☐ Nervous/Anxious
- ☐ Substance abuse
- ☐ Suicidal ideas

Allergy/Immuno
- ☐ Environmental allergies
- ☐ Hives

Sleep Disorder Risk Assessment

☐ Please check here if you have already been diagnosed with sleep apnea and are currently undergoing treatment. If this is the case, it is not necessary for you to complete remainder of this survey. *Thank you!*

What is Sleep Apnea?

Sleep apnea is the most common form of Sleep Disordered Breathing (SDB). It refers to a variety of breathing difficulties a person may experience while sleeping.

The symptoms listed in the checklist on this form describe many of the symptoms of sleep apnea. Often it is a sleep partner who recognizes these signs, and the patient is unaware of his or her unusual or irregular breathing during sleep. Some people with sleep apnea may stop and restart breathing hundreds of times in a single night.

What are the Risk Factors Associated with SDB?

Sleep apnea and snoring increase the risk for high blood pressure, heart failure, stroke, automobile and work-related accidents, and other affects of not getting enough sleep.

80% of uncontrolled high blood pressure patients suffer from Sleep Disordered Breathing (SDB).

50% of heart failure patients suffer from SDB.

45% of high blood pressure patients suffer from SDB.

30% of heart disease patients suffer from SDB.

How is SDB treated?

The good news is that SDB is easily treated. A number of treatment options are available that will improve quality of life.

Nearly half of all Americans suffer from sleep disorders. Please take this survey to help identify your risk.

☐ I have had a sleep study within the past 5 years or I am currently being treated for sleep apnea.

If you checked the above box, you do not need to complete the remainder of this sleep survey.

☐ I snore or I have been told I snore.

☐ I have been told I stop breathing when I sleep or sometimes I wake up snoring, gasping or choking.

☐ I have trouble staying asleep at night.

☐ I feel fatigued during the day.

☐ I feel sleepy or fall asleep at times during the day.

☐ My quality of sleep is poor and I don't feel refreshed upon awakening.

☐ I have been diagnosed with any of these: high blood pressure, atrial fibrillation or congestive heart failure.

If you have questions or concerns about a sleep disorder, please discuss during your visit.

TOTAL NUMBER OF BOXES CHECKED: _____

HCA PHYSICIAN SERVICES

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B. ☐

Section B: Required for all Authorizations for Release of PHI or Right to Access

Patient Name:	Birth Date:	Social Security No. *(optional)*:
Patient's Address:	Requestor's Name/Phone Number (if patient is not the requestor):	
PHI Recipient Name: Address/City/State/Zip		Phone Number: (__) _____ Fax Number: (__) _____
PHI Sender Name: Address/City/State/Zip		Phone Number: (__) _____ Fax Number: (__) _____

This authorization will expire on the following: (Fill in the Date or the Event, but not both.)
Date: Event:

Purpose of Disclosure:

Is this request for psychotherapy notes?
☐ Yes, then this is the only item you may request on this authorization.
☐ No, then you may check as many items below as you need.

Description:	Date(s)	Description:	Date(s)	Description:	Date(s)
☐ All PHI in record		☐ Physician Orders		☐ Demographics	
☐ History and Physical		☐ Laboratory		☐ Rehabilitation Services	
☐ Consult Report		☐ Imaging/Radiology		☐ Special Test/Therapy	
☐ Operative Report		☐ Nursing Notes		☐ Itemized Bill/Claims	
☐ Progress Notes		☐ Medication Record		☐ Other:	

I acknowledge, and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results or AIDS information. _____ (Initial) If not, applicable, check here ☐

I understand that:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy the information described on this form, for a reasonable copy fee, if I ask for it.
5. I will receive a copy of this form after I sign it.

Section C: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

Signature of Patient/Guardian/Patient Representative:	Date:
Print Name of Patient's Representative:	Relationship to Patient:

Original – Practice
Copy – Patient
Copy – Recipient

Revision Date: April 15, 2005