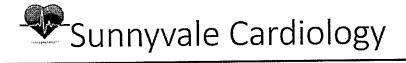
PATIENT NAME:	
DATE OF BIRTH:	SOCIAL SECURITY #:
ADDRESS:	· · · · · · · · · · · · · · · · · · ·
	•
	CELL/WORK PHONE #:
EMAIL ADDRESS:	
EMERGENCY CONTACT:	
EMERGENCY CONTACT F	PHONE NUMBER:
PRIMARY CARE PHYSICIA	AN NAME AND NUMBER:
PHARMACY NAME AND	NUMBER:
INSURANCE COMPANY:	
PATIENT SIGNATURE:	DATF:



AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

PATIENTS NAIVIE:
DATE OF BIRTH:SOCIAL SECURITY #:
AUTHORIZE AND REQUEST:
PHONE NUMBER: FAX NUMBER:
TO RELEASE MY PROTECTED HEALTHCARE INFORMATION TO:
SUNNYVALE CARDIOLOGY
182 S. COLLINS ROAD SUITE 800
SUNNYVALE, TEXAS 75182
PHONE NUMBER: 214-206-3695 / FAX NUMBER: 866-313-9413
THIS AUTHORIZATION AND REQUEST APPLIES TO HEALTHCARE INFORMATION
RELATING TO THE FOLLOWING TREATMENT, CONDITION, OR DATES:
PATIENT SIGNATURE: DATE:



FINANCIAL RESPONSIBILITY

, understand Sunnyvale Cardiology accepts my
Insurance Plan and the assignment of benefits as a courtesy to their patients. I
further understand that I (not the insurance company) have primary responsibility
for the full payment of services rendered. There will be a \$40 MISSED
APPOINTMENT FEE and a \$250 LATE CANCELLATION/ MISSED APPOINTMENT
FEE FOR ALL SCHEDULED NUCLEAR TESTING. We do require you to give our
office a 24/48-hour notice if you are not able to make your scheduled
appointment. By signing or not signing this document and having services
rendered, I fully accept and agree to meet my financial obligations to your office
for all denied Insurance claims and services rendered by Sunnyvale Cardiology.
•
Patient (Responsible Party) Date



HIPAA Privacy and Release of Information Authorization

hereby authorize Sunnyvale Cardiology and its affiliates, its employees and agents, to use and disclose protected health information (e.g., information relating to the diagnosis, treatment, claims payment and health care services provided or to be provided to me and which identifies my name, address, social security number, Member ID number) for the purpose of helping me to resolve Insurance claims and health benefit coverage issues.
I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws. I understand that I have a right to revoke this authorization by providing written notice. However, this authorization may not be revoked if, its employees or agents have acted on this authorization prior to receiving my written notice. I also understand that I have a right to have a copy of this authorization. I have been advised of this practices Release of Billing Information policy, Assignment of Benefits Policy and grant the practice Medication History Authority.
I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.
I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for a coverage of services.
If applicable, Legal Representatives sign below
By signing this form, I represent that I am the legal representative of the above-named patient and will provide written proof (e.g., Power of Attorney, living will, guardianship papers, etc.) that I am legally authorized to act on the Patients behalf with respect to this authorization.
Patient / Legal Representative Printed Name Date
Patient / Legal Representative Signature



AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

 Date
ve the right to revoke this authorization by o Sunnyvale Cardiology.
r health information may be released:
including information relating to any medical on and any treatment received by Sunnyvale
norize the release of the following health
Relationship:
Relationship:
Relationship: