LONE STAR
Cardiovascular Institute

NOTICE OF PRIVACY PRACTICES

THIS NOTICE DESCRIBES HOW HEALTHCARE INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INFORMATION. PLEASE REVIEW IT CAREFULLY.

Our commitment here at Lone Star Cardiovascular Institute is to serve our customers with professionalism and care, always being sure to protect the privacy and security of all Protected Health Information. While serving your interests, it may be necessary to share information with other healthcare providers or business associates. The following are examples of instances where information may be shared:

- During treatment, we may find it necessary to acquire a laboratory analysis.
- During healthcare operations, we may need a second opinion.
- During payment purposes, we may need to share medical records, progress notes, operative reports, etc.
- For collection purposes, we may use the services of a third-party collection company.

Lone Star Cardiovascular Institute and our staff are committed to obeying all federal, state and local laws and regulations regarding privacy practices. If there are any other uses or disclosures than the ones listed above are needed, information will only be released with the written authorization of the individual in question. The individual, as provided for by law, may revoke this written authorization at any time.

I understand that as part of the provision of healthcare services Lone Star Cardiovascular Institute creates and maintains health records and other information describing among other things, my health history, symptoms, examination and test results, diagnosis, treatment, and any plans for future care or treatment.

I understand that I have the right to review the Notice of Privacy Practices before signing this consent (Please request a copy from the receptionist if you wish to review). I understand that the organization reserves the right to change their Notice and practices and prior to implementation will mail a copy of any revised notice to the address I have provided. I understand that I have the right to object to the use of my health information for directory purposes. I understand that I have the right to request restrictions as to how my health information may be used or disclosed to carry out treatment, payment, or healthcare operations (quality assessment and improvement activities, underwriting, premium rating, conducting or arranging for medical review, legal services, and auditing functions, etc.) and that the organization is not required to agree to the restrictions requested.

By signing this form, I consent to the use and disclosure of protected health information about me for the purposes of treatment, payment and health care operations. I have the right to revoke this consent, in writing, except where disclosures have already been made in reliance on my prior consent. This consent is given freely with the understanding that:

1. All records, whether written or oral or in electronic format, are confidential and cannot be disclosed for reasons outside of treatment, payment or health care operations without my prior written authorization, except as otherwise provided by law.
2. A photocopy or fax of this consent is as valid as this original.
3. I have the right to request that the use of my Protected Health Information, which is used or disclosed for the purposes of treatment, payment or health care operations be restricted. I also understand that the Practice and I must agree to any restriction in writing that I request on the use and disclosure of my Protected Health Information; and agree to terminate any restrictions in writing on the use and disclosure of my Protected Health Information which have been previously agreed upon.
4. I have read and understand the above Notice of Privacy Practices.

Date: _____

Patient: _____
Signature of patient or responsible party

_____
Printed name of patient or responsible party (relationship if not self)

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