TENNESSEE VALLEY CARDIOVASCULAR CENTER

CONSENT TO TREAT

I authorize Tennessee Valley Cardiovascular Center physicians and staff to provide medical services to me and authorize the disclosure of protected health information for purposes of payment, healthcare operations, and treatment. This includes communication with my physicians, pharmacist, and hospitals by letter, phone, or fax. I understand that I have a right to request that Tennessee Valley Cardiovascular Center restrict the use or disclosure of protected health information for treatment, payment, and healthcare operations and that Tennessee Valley Cardiovascular Center may refuse this request, I understand that unless Tennessee Valley Cardiovascular Center has taken action in reliance on such consent, I may revoke this consent by giving written notice.

AUTHORATION TO LEAVE MESSAGES

I authorize Tennessee Valley Cardiovascular Center physicians and staff to leave messages regarding my medical condition including appointments, lab results, other test results, and information about medications, on my answering machine. This authorization will be in effect until I give written notice to Tennessee Valley Cardiovascular Center.

Agree__________ Disagree_____________

RECEIPT OF NOTICE OF PRIVACY PRACTICES

I acknowledge that I have received the Tennessee Valley Cardiovascular Center Notice of Privacy Practices; I understand that I will only receive another copy of the Notice if a change in the Privacy Practices occurs.

Signed____Date_____________