Dr. Abas A. Amiry, M.D., FACC, FSCAI

Amiry Cardiology Consultant MDSC

102A Fox Glen Court
Barrington, IL 60010
Phone: 224-848-4353
Fax: 224-848-4367

Acknowledgement of Receipt of Notice of Privacy Practice

PURPOSE OF CONSENT: By signing this form, you will consent to our use and disclosure of your protected health information to carry out treatment, payment activities and healthcare operations.

TREATMENT: Dr. A. Amiry may release/obtain any and all of your medical records concerning your care to/ from other health care professionals, physicians or hospitals providing care to you at any time.

PAYMENT ACTIVITIES: Dr. A. Amiry may release any and all of your medical records to Medicare, Medicaid, any other insurance company, third party payor or managed care company.

HEALTH CARE OPERATION: **Your physician or staff of Dr. A. Amiry may discuss your condition with members of your family or other individuals named by you below.****

We may attempt to contact you at the phone number you have provided to us and we may leave a message on voice mail or answering machine device concerning appointments or test results. In accordance with Federal Government privacy rules implemented through the Healthcare Portability Act (HIPAA) you have the right to read Our Notice of Privacy Practices before you decide whether to sign this consent. The notice provides a description of the uses and disclosures of your protected health information that will occur in my treatment, payment of bills or in the performance of healthcare operations of Dr. A. Amiry. This notice also describes my rights and Dr. A. Amiry's duties with respect to my protected health information. Dr. A. Amiry has the right to change the privacy practices described in this document. I may obtain a revised notice by calling the office and requesting a copy be sent in the mail or asking for one at the time of my appointment.

RIGHT TO REVOKE: You have the right to revoke this consent at any time by giving us a written notice of your revocation submitted to the contact person. Please understand that revocation of this consent will NOT affect action we took in reliance on this consent before we received your revocation and that we may decline to treat you or continue to treat you if you revoke this consent. I have full opportunity to read and consider the contents of this consent form and your Notice of Privacy Practices. I understand that by signing this consent form I am giving my consent to your use and disclosure of my protected health information to carry our treatment, payment activities and health care operations.

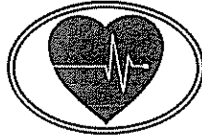
PRINTED NAME: ____

SIGNATURE: ____

DATE:_______/_______/_______ SOCIAL SECURITY: _______-_______-_______

**CONTACT NAME: ____

RELATION TO PATIENT:____________ PHONE NUMBER (   ) ______ - ________



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Authorization for Release of Health Information

DATE ______________________________

I hereby authorize Amiry Cardiology Consultants MDSC to release/obtain my records to/from:

____

____

____

Include any test results, diagnosis and records of any treatment or examinations rendered to me during the period from ________________ to ______________.

I understand that I will be charged a fee to released/copy my medical records.

I understand that I have the right to revoke this Authorization in writing at any time.

This Authorization will expire 3 months to the date indicated on this form.

PATIENT NAME (PLEASE PRINT) ____________________________________

DATE OF BIRTH____________________________

PATIENT SIGNATURE ____

WITNESS SIGNATURE ____