

**Pt Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_

**eMail address:** \_\_\_\_\_

**CONSENT TO HEALTH INFORMATION EXCHANGE**

I consent to allow my provider to use Health Information Exchanges (secure computer networks that allow participating health care and insurance providers nationwide to access healthcare information to enhance coordinate of care) to disclose information to other healthcare organizations or providers. I understand that I have a right to request and receive an accounting of disclosures of access to my information through the HIE at any time.

**DATE:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Parent if Minor**

**CONSENT TO TREATMENT**

**(All Patients)**

I am presenting myself for examination and treatment at LGH Merrimack Valley Cardiology Associates, LLC and I voluntarily consent to the rendering of such care encompassing routine diagnostic procedures and medical treatment, by authorized agents and employees of the practice, and by its medical staff, or their designees, as in their professional judgment be deemed necessary or beneficial. I further authorize electronic access of my pharmaceutical records, if applicable, for treatment purposes. I understand that my records will only be accessed by authorized individuals.

I am aware that the practice of medicine is not an exact science and I acknowledge that no guarantees have been made to me as a result of treatments or examinations in the practice.

I understand that information about my health may be disclosed to public health authorities charged with preventing or controlling disease.

\_\_\_\_\_  
**Signature of Patient or Responsible Person\*\***

\_\_\_\_\_  
**Relationship**

\*\* By signing above, I acknowledge that LGH Merrimack Valley Cardiology Associates, LLC has informed me of their **Notice of Privacy Practices** for the protection and security of my healthcare information. I also acknowledge that upon request, LGH Merrimack Valley Cardiology Associates, LLC will provide me with a copy of their **Notice of Privacy Practices**.

**FINANCIAL CONSENTS**

**(All Patients)**

**Release of Information: Assignment of Benefits, Payment Guarantee**

**AUTHORIZATION TO RELEASE INFORMATION:** LGH Merrimack Valley Cardiology Associates, LLC is authorized to release to any insurance companies having coverage on me (or to the employer if coverage is under a group insurance plan) any information pertaining to the diagnosis and/or procedures relative to this practice visit(s). A photo copy of this authorization shall be considered as effective and valid as the original.

**ASSIGNMENT OF INSURANCE BENEFITS AND RIGHT OF RECOVERY:** In consideration of services rendered, I hereby forever assign and give to LGH Merrimack Valley Cardiology Associates, LLC all rights, title and interest in the benefits payable for services rendered by said practice, provided by my policy (ies) of insurance. This transaction shall be for the recovery on said policy (ies), but shall not be construed to be an obligation of LGH Merrimack Valley Cardiology Associates, LLC to pursue any such right of recovery. Provided, however, this assignment and transfer shall not take away my standing to make claim or sue for benefits individually should coverage be denied by any insurance carrier(s). I hereby authorize the insurance company (ies) to pay directly to LGH Merrimack Valley Cardiology Associates, LLC all benefits due under said policy (ies) by reason of services rendered therein. I shall pay LGH Merrimack Valley Cardiology Associates, LLC for all charges in excess of the sums actually paid pursuant to said policy (ies). A photo copy of this authorization shall be considered as effective and valid as the original.

3/14/2018

\_\_\_\_\_  
**Signature of Patient or Parent if Minor**

**MEDICARE CERTIFICATION**

**(Medicare Patients Only)**

**Patient's Certification, Authorization to Release Information and Payment Request:** I certify that the information given by me in applying for insurance and/or Medicare payment is true and correct. I authorize LGH Merrimack Valley Cardiology Associates, LLC to act as my agent in helping me obtain payment of my insurance and/or Medicare benefits, and I authorize payment of these benefits directly to LGH Merrimack Valley Cardiology Associates, LLC or one of its affiliates on my behalf for any services and materials furnished. I authorize any holder of medical information about me to release to the Centers for Medicare and Medicaid Services and its agents any information needed to determine these benefits payable to related services. I further agree that I will furnish evidence along with the Medical Insurance Policy number(s) that said insurance plan payments have been exhausted or unavailable for payment prior to payment submission and anticipation of payment by Medicare. I assign payment for the unpaid charges for certain physician's services. I understand that I am responsible for any health insurance deductibles and coinsurance.

\_\_\_\_\_  
**Signature of Patient**

**AUTHORIZATION TO RELEASE INFORMATION**

**(All Patients)**

I allow LGH Merrimack Valley Cardiology Associates, LLC to speak to my family members regarding my care.

I allow LGH Merrimack Valley Cardiology Associates, LLC to leave a message at my home or cell regarding any appointments and/or normal test results.

**DATE:** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Parent if Minor**

**Pt Name:** \_\_\_\_\_

**DOB:** \_\_\_\_\_



PT NAME: \_\_\_\_\_ DOB: \_\_\_\_\_

ADDRESS: \_\_\_\_\_

\_\_\_\_\_

Patient Authorization For Release of Protected Health Information

I, \_\_\_\_\_ hereby,  
authorize release of my protected health information (information contained in my medical record) to the following entity.

Merrimack Valley Cardiology Associates, Inc.  
Att: Medical Records  
14 Research Place, No. Chelmsford, MA 01863  
Phone: 978-256-6607  
Fax:978-250-8189

**PLEASE FAX TO: 978-250-8189**

Description of information to be Disclosed: ANY OF THE FOLLOWING RECORDS:

- 1: Most Recent Office Visit note
- 2: Recent Blood Lab results/prior EKG
- 3: Any prior cardiac testing: CT, MRI  
Echocardiograms, ETT Sress tests / Nuclear imaging, Cardiac Monitor reports, etc...
- 4: Hospital (Cardiology) Consults, History  
& Physical reports, Cardiac Procedure  
reports and Discharge Summaries

**PATIENT or** Legal Guardian Signature: \_\_\_\_\_

If Authorized individual, relationship to patient: \_\_\_\_\_

Date Signed: 3/14/2018