Maika'i Hearts
HAWAI'I CARDIOLOGY

EMERGENCY CONTACT & CONSENT

EMERGENCY CONTACT

Name ______________________________ Phone ____________________ Relationship ________________

Name ______________________________ Phone ____________________ Relationship ________________

Name ______________________________ Phone ____________________ Relationship ________________

*I verify that all information is correct. I understand that I am financially responsible for all charges, regardless of insurance coverage. I request that payment of insurance benefits be made on my behalf to: **Giselle A. Baquero MD, FACC**, for services furnished to me.*

Signature____ Date __________________________
Patient/Legal Guardian

Consent for Use/Disclosure of Health Information

Notice to Patient: By signing this form, you grant us consent to use and disclose your protected health care information for the purposes of treatment, various activities associated with payment and health care operations. Our Notice of Privacy Practices provides more details on our treatment, payment and health care operations. We encourage you to read it. As stated in our Notice of Privacy Practices, we reserve the right to change our privacy practices. You may refuse to sign this acknowledgment if you wish, though we may decline to treat you.

This authorization also allows Giselle A. Baquero MD, FACC, permission to speak to the following individuals, or leave a message on voice mail regarding my medical information and treatment:

Name ______________________________ Relationship ________________

Name ______________________________ Relationship ________________

Name ______________________________ Relationship ________________

Name ______________________________ Relationship ________________

(To be completed by Patient or Patient's Representative)

I, __________________________, have read the contents of this Consent form and the Notice of Privacy Practices and acknowledge receipt of a copy of the Notice of Privacy Practices. I understand that I am giving you my consent to use and disclose my health care information to carry out treatment, payment activities and health care operations.

All medical information with no exceptions will be disclosed and/or requested as necessary. I authorize faxing of information as necessary. This authorization shall cover the period of time from my first visit to my last visit and will end 2 years after the date of my last visit. I permit a copy of this authorization to be used in place of original.

Signature____ Date __________________________
Patient/Legal Guardian