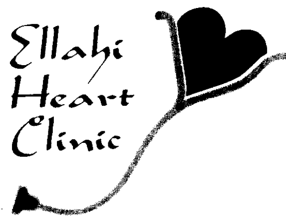

**Atif Sohail M.D. F.A.C.C.**

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Interventional Cardiology
Cardiovascular Diseases

**PATIENT CONSENT**

Patient Consent for purposes of Treatment, Payment and Healthcare Operations: By signing this form, I consent to the use or disclosure of my protected health information by Ellahi Heart Clinic, P.A. for the purpose of providing treatment to me, obtaining payment for my healthcare bills or to conduct Ellahi Heart Clinic, health care operations. I understand that I have the right to revoke this consent, in writing, at any time, except to the extent that Ellahi Heart Clinic, P.A. has taken action in reliance on my prior consent. I certify that I have received a copy of Ellahi Heart Clinic, P.A. Notice of Privacy Practices.

Release of Medical Information: I authorize release of any and all medical records, related Medical Information and billing information regarding my treatment for the purposes of substantiating insurance coverage and medical payment owed to this facility for all or part of the charges involving my care or the care of my family member for treatment. This authorization includes but is not limited to hospital or medical service companies, insurance Companies, worker's compensation carriers, or welfare funds.

I authorize any holder of medical information about me to release to the Social Security Administration, or its intermediaries, or the Medicaid agency, or its intermediaries, any information needed for the processing of a Medicare or Medicaid claim.

I also authorize other healthcare providers and facilities that have provided examination, diagnosis and/or treatment to me, or my family member, to release any and all medical records and related information regarding my diagnosis and treatment, to or by other healthcare providers for the purposes stated above.

I agree and consent to the release of any and all of aid records and medical information by oral, written, or electronic means of communication, to or from this facility to the parties stated above. Ellahi Heart Clinic, P.A. will not be responsible for the loss of, miscommunication or retrieval of, or confirmation of any electronically transmitted or non-certified correspondence to or from this facility.

**I certify that I have read these Financial Policies and Consent Procedures and understand and agree to be personally and fully responsible for payment.**

______________________________ ______________
Patient/Guardian Signature Date

______________________________ ______________
Witness Date