Nipun Arora, M.D. FACC
Vikas Verma, M.D. FACC

ORLANDO CARDIAC & VASCULAR SPECIALISTS LLC

Rajesh Shah, M. D. FACC
Sambit Mondal, M.D. FACC

Patient Consent / Notice of Privacy Practices Acknowledgement Form

I understand that, under the Health Insurance Portability & Accountability Act of 1996 (HIPAA), I have certain privacy rights related to my protected health information (PHI). I understand this information can be used to 1) conduct, plan and direct my treatment and follow up among multiple healthcare providers who may be involved in such treatment directly and indirectly, 2) obtain payment from third party payers, and 3) conduct normal healthcare operations such as quality assurance and physician certifications.

I have been informed of Orlando Cardiac & Vascular Specialists LLC's Notice of Privacy Practices which provides a more complete description of how my PHI may be used or disclosed. I understand that I have the right to review this Notice before signing this form. I understand that this organization has the right to change its Notice of Privacy Practices from time to time and that I may contact this organization at any time at their address to obtain a current copy of the Notice.

By signing this form, I consent to Orlando Cardiac & Vascular Specialists LLC's use and disclosure of my protected health information to carry out treatment and health care operations and/or determine a claim for payment as described in their Notice.

I understand that while this consent is voluntary, this organization can refuse to treat me should I refuse to sign it. I further understand that I have the right to request how my PHI is used or disclosed to carry out treatment, payment or health care operations. I also understand that the organization is not required to agree to my restrictions, but if they do agree, then they are bound to abide by such restrictions.

I understand that I may revoke this consent in writing at any time, except to the extent that the organization has already made releases relying on my prior consent.

Patient Name (Print): _____

Patient Signature: _____

Date: _____

Witness: _____

251 Maitland Ave., Suite 116, Altamonte Springs, FL 32701 ***Tel: 407.915.5643***
1301 South International Pkwy., Suite 1001, Lake Mary, FL 32746 ***Fax: 407.960.2602***