



SHORE CARDIOLOGY CONSULTANTS

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HIPAA FORM

I understand that Shore Cardiology Consultants, LLC is part of an organized healthcare arrangement that includes Dr. Ali R. Moosvi, Dr. Todd S. Cohen, and Dr. Michael G DeVita. These providers may share my health information for treatment, billing and healthcare operations. I have been given a copy of the organization's notice of privacy practices that describes how my health information is used and shared. I understand the organized healthcare arrangement has the right to change this notice at any time. I may obtain a current copy by contacting the hospital registration office or my doctor's office. I understand that I have the right to revoke or change this authorization at any time after giving notification in writing to Shore Cardiology Consultants, LLC.

LIMITATIONS:

1. Organizations/ persons to whom I do **NOT** authorize any healthcare information to be sent.

2. My healthcare information/scheduling issues can be discussed with my family member(s) or be recorded on my answering machine if I am unavailable.

I authorize (please initial) _____ I do **NOT** authorize (please initial) _____

My signature below constitutes my acknowledgment that I have been provided with a copy of the notice of privacy practices:

Signature of Patient or Legal Representative

Date

Print Name

Consent to Obtain Medication History

Our computer system allows us to collect and review your "medication history." A medication history is a list of prescription medicines that we or other doctors have recently prescribed for you. This list is collected from a variety of sources, including your pharmacy and your health insurer. An accurate medication history is very important to helping us treat you properly and in avoiding potentially dangerous drug interactions. By signing this consent form you give us permission to collect, and give your pharmacy and your health plan permission to disclose information about your prescriptions that have been filled at any pharmacy or covered by any health insurance plan. It is very important for us to know what you are taking including any over the counter medicines, supplements, or herbal remedies. I understand that I have the right to revoke or change this authorization at any time after giving notification in writing to Shore Cardiology Consultants, LLC.

I authorize (please initial) _____ I do **NOT** authorize (please initial) _____

My signature below constitutes my acknowledgment that I agree to the above:

Signature of Patient or Legal Representative

Date

Print Name