Heart Institute of Wisconsin, S.C.

Consent to Use and Disclosure Protected Health Information

I consent to the use or disclosure of my protected health information by Heart Institute of Wisconsin, S.C. for the purpose of diagnosing or providing treatment to me, obtaining payment for my health care bills or to conduct the health care operations of Heart Institute of Wisconsin, S.C..

By signing this form, I give consent for Heart Institute of Wisconsin, S.C. to use and/or disclose my health information for treatment, payment or health care operations.

Signature of Patient or Personal Representative _____ Date _____

Print Name of Patient or Personal Representative _____

Description of Personal Representative's Authority _____