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PRACTICE LIMITED TO CARDIOVASCULAR DISEASES

AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient:_____ Date of Birth:_____ SSN: _____

Type of Release of Authorization

_____ I authorize the above-named physicians to **RELEASE** Protected Health Information **to**:

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____ _____
(Phone No.) (Fax No.)

_____ I authorize the above-named physicians to **OBTAIN** Protected Health Information **from**:

_____
(Name)

_____
(Address)

_____
(City, State, Zip)

_____ _____
(Phone No.) (Fax No.)

Extent of Nature of Information to be Disclosed, including Dates of Treatment or Hospitalization

_____Office Note _____Labs _____X-Rays _____Consultation Reports _____Other:_____

Purpose or Need for Disclosure

_____Attorney _____Insurance _____Medical Care _____Personal _____Other:_____

1. I may inspect or receive a copy of the Protected Health Information described by this authorization.
2. I understand that this authorization is applicable to patients with drug or alcohol related diagnoses, in which Title 42, Part 2 of the Code of Federal Regulations and/or the New York State Mental Hygiene Law, governs this request.
3. I understand that my medical records may contain genetic testing information including lab results.
4. I understand that treatment and payment will not be conditional on whether I provide authorization for any requested additional written authorization on my part.
5. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.
6. I understand that when the information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the receiver and may no longer be protected by the federal or state rule.
7. I understand this authorization may be revoked by written notification from the undersigned to this office, except to the extent that action has been taken in reliance upon this authorization.
8. I am aware there may be a fee associated with the production of copies.
9. This authorization will expire within one year unless otherwise specified.

_____ _____
Signature of Witness (Date) Signature of Patient/Representative (Date)