

AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

SECTION A:

I hereby authorize the use of disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the released information no longer may be protected by federal privacy regulations.

PATIENT NAME: _____ ID#: _____

PERSONS/ORGANIZATIONS PROVIDING THE INFORMATION:
Cardiovascular Interventions P.A./Preventive Health Care

PERSONS/ORGANIZATIONS RECEIVING THE INFORMATION:
Family Members/Friends: _____

SPECIFIC DESCRIPTION OF INFORMATION (INCLUDING DATES):
All medical information from my initial visit through ____/____/____
Exclusions: _____

SECTION B:

1. I understand that my health care and the payment for my health care will not be affected if I do not sign this form. INITIALS: _____
2. I understand that I may see and request a copy of the information described on this form if I ask for it. INITIALS: _____

SECTION C:

1. I understand that this authorization will expire in 1 year. INITIALS: _____
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, but if I do it won't have any affect on any actions that took place before the revocation was received. INITIALS: _____

You have the right to revoke this authorization at any time, provided that you do so in writing and except to the extent that we have already used or disclosed the information in reliance with this authorization.

Unless revoked earlier or otherwise indicated, this authorization will expire in 1 year from the date of signing or shall remain in effect for the period reasonably needed to complete the request

I have reviewed and I understand this authorization. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected under federal law.

BY: _____ DATE: _____
(Patient)

OR BY: _____ DATE: _____
(Patient's Representative)
Description of Representative's Authority _____

EFFECTIVE DATE April 14, 2003

**Written Acknowledgement
Receipt of Notice of Privacy Practices**

I acknowledge that I have reviewed and received a copy of the Notice of Privacy Practices, which provides a description of information uses and disclosures. I understand that I have the right to request restrictions as to how my health information may be used or disclosed and that the organization is not required to agree to the restrictions I request.

Signature of Patient or Legal Representative

Witness

Date