Elite Cardiac & Vascular Care

STANDARD AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Name: Last: _____ First: _____ Middle Initial: _____

Date of Birth: _____/_____/_____

Authorization for Use/Disclosure of Information: I voluntarily authorize and direct the health care provider named below to disclose my health information during the term of this Authorization to the recipient that I have identified below.

Name of Provider: _____

Address of Provider: _____

_____

Fax Number: _____

Recipient and Address for Delivery of Records:

Purpose: I understand that the specific purpose of this Authorization is

_____

Information to be disclosed: This authorization permits the above named health care provider to disclose the following medical records:

All of my health information that the provider has in his or her possesion, including information relating to any medical history, mental or physical condition and any treatment received by me, including without limitation, x-ray, HIV/AIDS status, genetic testing, psychotheraphy notes and other mental health information, drug, alcohol or other controlled substance information, billing information, correspondence, and records from my other health care providers that the above named health care provider may hold.

All of my health information described above except for following:

_____

Only the following records or types of health information: Insert dates of treatment, types of treatment or other designation.

_____

Term: This Authorization will remain in effect for one (1) year from the date this authorizaton is signed.

Redisclosure: I understand that once my health care provider disclosure my health care information to the recipient indentified above, my health care provider cannot guarantee that the recipient will not redisclose my health information to third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

Revocation: I understand that the Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation to my health care provider at my health care provider's regular office address. The revocation will be effective immediately upon my health care provider's receipt of my written notice, except that the revocation will not have any effect on any action taken by my health care provider in reliance on this Authorization before the provider received my written notice of revocation.

Photocopy: A photocopy, fax or electronic copy of this Authorization shall be considered as effective and as valid as the original.

Signature: _____ Date: _____ Signature of Witness: _____

Name : _____ (Please Print)

If Individual is unable to sign this Authorization, please complete the information below:

Signature of Personal Representative : _____ Witness Signature: _____

Legal Relationship: _____ Date: _____

Name : _____ (Please Print)