Cardiovascular Care Associates

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

Patient Address: _____ Social Security #:_____

City/State/Zip:_____

Maiden/Other Names: _____ Telephone #: _____

1. I authorize Cardiovascular Care Associates, PLC to use and/or disclose confidential health information about me by requesting/releasing a copy of my medical record.
2. Name and address of person or organization to whom disclosure of my confidential health information is to be made to/from:

_____

3. The authorization shall expire 120 calendar days from the date of signature or upon completion of this request.
4. I understand that I may revoke this authorization by contacting Cardiovascular Care Associates, PLC and requesting an authorization revocation form to fill out and return.
5. I understand that the right to revoke this authorization is not approved if Cardiovascular Care Associates, PLC has taken action in reliance upon this Authorization.
6. I understand that my confidential health information that is disclosed under this Authorization may be subject to re disclosure by the recipient, and the privacy of my confidential health information will no longer be protected by the law.
7. Specific type of information to be disclosed (include dates and type of treatment): _____

_____

8. The purpose and need for disclosure: _____

By signing this Authorization, I acknowledge that I have read and understand this Authorization.

_____ _____

Signature (Patient) Date Signature (Authorized Representative) Date

_____ _____

Printed Relationship of Authorized Representative

A COPY OF THE SIGNED AND DATED AUTHORIZATION IS GIVEN UPON REQUEST