TheHeartGroup
Cardiovascular Associates Inc.
A MEMBER OF COMMUNITY FOUNDATION MEDICAL GROUP & PART OF SANTE' HEALTH FOUNDATION

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AUTHORIZATION FOR USE AND/OR DISCLOSURE OF MEMBER/PATIENT HEALTH INFORMATION

Neither treatment, payment, enrollment, or eligibility for benefits will be conditioned on my providing or refusing to provide this authorization.

I Hereby Authorize: ______________________________
NAME OF DISCLOSING PARTY

____
ADDRESS

____
CITY STATE ZIP

to disclose to: ______________________________
NAME OF RECEIVING PARTY

____
ADDRESS

____
CITY STATE ZIP

Records and Information Pertaining to:

______________________________ ______________ ______________
NAME OF PATIENT (LIST OTHER NAMES USED) MEDICAL RECORD NUMBER DATE OF BIRTH

______________________________ ______________
ADDRESS TELEPHONE NUMBER

DURATION: This authorization shall become effective immediately and shall remain in effect until ______________ (DATE) or for one year from the date of the signiture.

REVOCATION: This authorization is also subject to written revocation by the undersigned at any time between now and the disclosure of information by the disclosing party. My written revocation will be effective upon receipt, but will not be effective to the extent that the Requester or others have acted in reliance upon this Authorization.

REDISCLOSURE: I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

SPECIFY: Check the box and initial to specify which type of information is to be disclosed.

☐ **MEDICAL INFORMATION**
__________ INITIAL __________ DATE

☐ **PSYCHIATRIC INFORMATION**
__________ INITIAL __________ DATE

☐ **RESULT OF HIV BLOODTEST**
__________ INITIAL __________ DATE

☐ **DRUG/ALCOHOL INFORMATION**
__________ INITIAL __________ DATE

☐ **OTHER HEALTH INFORMATION**
__________ INITIAL __________ DATE

Specify the records to be disclosed:______________________________

____

____

Patient Signature:______________________________ **Date:**______________