



**AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION**

I, \_\_\_\_\_, hereby voluntarily authorize the disclosure of information from my record for the purpose of \_\_\_\_\_. (continuing care, insurance application, etc.)

SS# \_\_\_\_\_ DOB \_\_\_\_\_

**The information is to be DISCLOSED BY:**

**Information is to be PROVIDED TO:**

\_\_\_\_\_  
Name of Facility/Doctor

\_\_\_\_\_  
Name of Person/Organization/Facility

\_\_\_\_\_  
Address

\_\_\_\_\_  
Address

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
City/State/Zip

\_\_\_\_\_  
Phone/Fax

\_\_\_\_\_  
Phone/Fax

**The information to be disclosed from my health record: (check appropriate boxes)**

- Entire record
- Only information related to (specify- echo, stress, office visit) \_\_\_\_\_
- Only the period of events from \_\_\_\_\_ to \_\_\_\_\_
- Other (specify) \_\_\_\_\_

**I authorize the disclosure of the following sensitive information: (check appropriate boxes)**

- Yes  No  Alcohol/Drug abuse treatment/referral
- Yes  No  HIV/AIDS-related Treatment
- Yes  No  Sexually Transmitted diseases
- Yes  No  Mental Health

I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law.

I understand that I have the right to revoke this authorization, in writing, at any time to Cardiovascular Medicine, P.C., 1236 E. Rusholme St, Suite 300, Davenport, Iowa. 52803. I understand that such a revocation is not effective to the extent that Cardiovascular Medicine, has relied on the use or disclosure of the protected health information. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event. \_\_\_\_\_(enter expiration date/event)

I understand that Cardiovascular Medicine, will not condition treatment or eligibility for care on my providing this authorization except if such care is provided solely for the purpose of created Protected Health Information for disclosure to a third party.

I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule

\_\_\_\_\_  
Signature of patient or legal representative

\_\_\_\_\_  
date