ADVANCED INTERVENTIONAL CARDIOLOGY CONSULTANTS

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PATIENT AUTHORIZATION FOR USE AND DISCLOSURE OF HEALTH INFORMATION

PRINT NAME: I, _____

DOB_____/_____/_____ by signing this authorization form, authorize the use and disclosure of my health information in the manner described below. I have signed this form voluntarily in order to document my wishes regarding the use and disclosure of the health information described below in Section 1.

Health Information to be released is to be used/disclosed for Continuity of Care

1. Description of Health Information I Authorize to be Used and Disclosed.

☐ ALL Medical Records ☐ or: _____

I understand that the above information I have authorized to be used and disclosed may contain information related to HIV / AIDS, sexually transmitted diseases, mental health (excluding psychotherapy notes), alcohol or substance abuse and genetic testing unless otherwise restricted by me. List any restrictions:

☐ NONE Patient's Initials: _____ ☐ Yes, I have the following restrictions _____

2. Persons/Organizations Authorized to Disclose My Health Information.

☐ Advanced Interventional Cardiology Consultants

☐ Other: _____

3. Persons/Organizations Authorized to Receive My Health Information.

☐ Advanced Interventional Cardiology Consultants

☐ Other: _____

I understand that if the persons/organizations listed above are not health care providers, health plans or health care clearinghouses subject to federal privacy standards, the health information disclosed pursuant to this authorization may no longer be protected by the federal privacy standards and such person(s) and organization(s) may re-disclose my health information without obtaining my authorization. Therefore, I release Advanced Interventional Cardiology Consultants, Inc. from all liability arising from this disclosure of my health information.

4. Your Rights with Respect to this Authorization.

I understand that I have the right to inspect or receive a copy of the health information I have authorized to be used or disclosed. I may arrange to inspect my health information or obtain copies of my health information by contacting the Privacy Contact. I understand that if I agree to sign this authorization, at my request, I must be provided with a signed copy of it.

5. Impact of this Authorization on Other Privacy Regulations.

I understand that this authorization does not preclude Advanced Interventional Cardiology Consultants, Inc. from releasing my protected health information in a manner not described above, pursuant to state and federal privacy laws.

_____ _____

Patient's Signature Personal Representative (if applicable)

Witness' Initials:_____ Today's Date: _____/_____/_____

This authorization is valid for 12 months from the date it was signed.