Authorization for Disclosure of Protected Health Information

I authorize the Heart Center for Excellence to use or disclose the protected health information of the individual named below as indicated. Incomplete or invalid requests will be returned to the proper individual.

Patient Name:	Patient #:
Address:	Date of Birth:
City:	Phone:
State:	Zip:

This authorization is for the following information (check those that apply and indicate the needed date(s) of service):

_____ Office Notes
_____ Diagnostic Tests
_____ Other ___________________________
_____ Laboratory Reports
_____ Radiology Reports

Date(s) of service to used/disclosed:
___/____/_____ to ___/____/_____

Other: ________________________

The Heart Center for Excellence at 1722 Shaffer Road, Suite #1, Kalamazoo, Michigan, 49048 is authorized to *SEND/RECEIVE* the above information to the following person or group:

____
Person/Group

____
Address

____
City, State, Zip

The purpose for this request in (check one):

_____ Continuous care
_____ Legal
_____ Insurance
_____ Disability
_____ Other

I understand that sensitive information regarding HIV/AIDS, alcohol and drug abuse and/or mental health treatment may be released as part of this disclosure.

I understand that by signing this authorization is not required in order for me to receive treatment except as indicated in any privacy practices notices I have received. I understand that I can revoke this authorization in writing by sending notice to the facility releasing the above information. I understand that once information is disclosed it may no longer be protected by federal or state privacy rules and therefore may be re-disclosed by the recipient of the information with protections.

Unless otherwise indicated here this authorization shall expire in one year.
Other Expiration Date: ___________________

I understand the terms of this form and authorize the disclosure/use as indicated above.

____ ___________________________
Patient (or Patient Representative) Signature Date

If signed by patient representative, print authority to do so and attach documentation to verify this fact:

_________________________________ ____ ___________________
Authority Witness Signature Date