Centennial Heart CARDIOVASCULAR CONSULTANTS

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Section A: Will the Protected Health Information (PHI) be created or used for research and include treatment of the patient? If yes, complete the Authorization for Research Form. If no, proceed to Section B.

Section B: Required for all Authorizations for Release of PHI or Right to Access

PATIENT NAME:	BIRTH DATE:	SOCIAL SECURITY NO. *(Optional)*:
PATIENT'S ADDRESS:	REQUESTOR'S NAME/PHONE NUMBER (IF PATIENT IS NOT THE REQUESTOR):	
PHI RECIPIENT NAME: ADDRESS/CITY/STATE/ZIP		PHONE NUMBER: ( ) FAX NUMBER: ( )
PHI SENDER NAME ADDRESS/CITY/STATE/ZIP		PHONE NUMBER: ( ) FAX NUMBER: ( )
THIS AUTHORIZATION WILL EXPIRE ONE YEAR FROM DATE OF SIGNATURE		
PURPOSE OF DISCLOSURE:		

DESCRIPTION:	DATE(S)	DESCRIPTION:	DATE(S)	DESCRIPTION:	DATE(S)
☐ ALL PHI IN RECORD ☐ HISTORY AND PHYSICAL ☐ CONSULT REPORT ☐ OPERATIVE REPORT ☐ PROGRESS NOTES		☐ PHYSICIAN ORDERS ☐ LABORATORY ☐ IMAGING/RADIOLOGY ☐ NURSING NOTES ☐ MEDICATION RECORD		☐ DEMOGRAPHICS ☐ REHABILITATION SERVICES ☐ SPECIAL TEST/THERAPY ☐ ITEMIZED BILL/CLAIMS ☐ OTHER:	

I ACKNOWLEDGE, AND HEREBY CONSENT TO SUCH, THAT THE RELEASED INFORMATION MAY CONTAIN ALCOHOL, DRUG ABUSE, PSYCHIATRIC, HIV TESTING, HIV RESULTS OR AIDS INFORMATION. _____(INITIAL)
IF NOT APPLICABLE, CHECK HERE ☐

I UNDERSTAND THAT:

1. I may refuse to sign this authorization and my treatment will not be conditioned upon signature of this authorization (except for non-health related services such as pre-employment testing, life insurance exams, or drug screenings).
2. I may revoke this authorization at any time in writing, but if I do, it will not have any affect on any actions taken prior to receiving the revocation. Further details may be found in the Notice of Privacy Practices.
3. If the requester or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be re-disclosed.
4. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it.

Section C: The request of PHI is for the purpose of marketing

Will the recipient receive financial or in-kind compensation in exchange for using or disclosing this information?	☐ Yes ☐ No

If yes, describe:

Section D: Signatures

I have read the above and authorize the disclosure of the protected health information as stated.

SIGNATURE OF PATIENT/GUARDIAN/PATIENT REPRESENTATIVE:	DATE:
PRINT NAME OF PATIENT'S REPRESENTATIVE:	RELATIONSHIP TO PATIENT:

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