Cardiovascular Consultants Heart Center
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KEVIN J. BORAN, MD, FACC, FSCAI / W. EDWARD HANKS, MD, FSCAI / DONALD W. GREGORY, MD, FACC
ROHIT SUNDRANI, MD, FACC, FSCAI / MICHAEL W. GEN, MD, FACC, FSCAI / CHANDRASEKAR PALANISWAMY, MD, FACC, FHRS

Authorization to Disclose Personal Health Information

Patient Name: (Print clearly) _____

Address: _____

Contact Number: _____

Patient Date of Birth: _____

Information will be used for the purpose of: ☐ **Continued Care** ☐ Other: _____

To whom do you want your personal health information released to:

☐ Kevin J. Boran, MD, FACC, FSCAI
☐ W. Edward Hanks, MD, FSCAI
☐ Donald W. Gregory, MD, FACC
☐ Rohit Sundrani, MD, FACC, FSCAI
☐ Michael W Gen, MD, FACC, FSCAI
☐ Chandrasekar Palaniswamy, MD, FACC, FHRS

Name and address of the person or organization you are requesting your personal health information released from:

Name / Organization: (Print clearly) _____

Address: _____

Disclosure for: ☐ **Specific Date of Service:** _____
☐ **All Records**

Information is to be: ☐ Mailed
☐ Faxed: (_____) _____
☐ Picked up in person by _____ (Name)

I understand that this authorization:

- Prohibits further use or disclosure of the information being released beyond the specific limits of this consent.
- Includes all medical records or other information regarding my treatment, hospitalization, and/or outpatient care for my condition, including psychological or psychiatric impairment, drug abuse and/or alcoholism, Acquired Immunodeficiency Syndrome (AIDS), or tests for or infection with Human Immunodeficiency Virus (HIV).
- **Expires in one (1) year from the date of signature.**
- This authorization may be revoked at any time by my written request, effective upon receipt.
- I understand that I have a right to a copy* of this authorization. ***(Copy Requested and Received. Initial Here _____)**

Patient Signature Or Signature of Representative with a copy of Power of Attorney. **Note:** Legal documentation is required to verify your representation as parent, conservator, guardian or medical decision-making authority for the above patient.

_____ **Date**: _____
Signature of patient or personal representative

_____
Printed name of patient or personal representative with authority to make medical decisions.