Cardiovascular Consultants Heart Center

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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
☐ Donald W. Gregory, MD, FACC
☐ Rohit Sundrani, MD, FACC, FSCAI
☐
☐ Chandrasekar Palaniswamy, MD, FACC, FHRS
☐ Ajay M. Patel, MD, FACC, FSCAI
☐ Kumar Sanam, MD, FACC
☐ ______________________________

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. **N**ote: 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.