Cardiology Associates, Inc.
Authorization for Use or Disclosure of Protected Health Information (PHI)

Patient Name:

Patient Address
City, State, Zip Code

FROM

I authorize the use and/or disclosure of my PHI from:

Name: Cardiology Associates, Inc.

Address: 621 Memorial Drive, Suite 502, South Bend, IN 46601-1066

TO

I authorize the use and/or disclosure of my PHI to:

Name: _____

Address: _____
(Street) (City/State) (Zip)

Specific information to be released: _____

This PHI is being used or disclosed for the following purpose(s): _____

_____

This authorization shall be in force and effect until 6 months after the date signed below at which time this authorization to use or disclose PHI expires.

I understand that:

- I have the right to revoke this authorization, in writing, at any time by sending such written notification to Privacy Contact at Cardiology Associates, Inc. I understand that a revocation is not effective to the extent that Cardiology Associates, Inc has relied on the use or disclosure of the protected health information.
- Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- This authorization is voluntary. Cardiology Associates, Inc. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure.
- I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights), refuse to sign this authorization and receive a signed copy of this authorization.
- If no expiration date or event is specified above, this authorization is valid for a period of six (6) months from the date of signature.

_____ _____
Signature of Patient or Personal Representative **Date Signed**

_____
Name of Patient or Personal Representative

_____
Description of Personal Representative's Authority

I:\Winword\Forms\Release of Info HIPA 06-21003