CAPITAL HEART ASSOCIATES, P.A.

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INVASIVE, INTERVENTIONAL, NON-INVASIVE CARDIOLOGY AND PERIPHERAL VASCULAR DISEASE

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PATIENT AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

I, ________________________________, (date of birth:__________) understand Capital Heart Associates is authorized by me to use or disclose my protected health information for purposes (of) (other than) treatment, payment, or health care operations. I have read this authorization and understand what information will be used or disclosed, who may use and disclose the information, and the recipient(s) of that information. I specifically authorize any current employee or owner of Capital Heart, or any other individual listed below to disclose my protected health information as described on this form to the recipients listed below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information. I further understand that I retain the right to revoke this authorization, if done so according to the steps set forth below.

List the information to be used or disclosed. Be specific (*i.e., EKG, office notes, stress test, etc*.)

____

____

[ ] Include demographic information.

Name of person(s), other than Capital Heart employees or owner(s) authorized by this form to use and disclose the patient's protected health information: ____

Purpose of the information disclosure: ____

Check if applicable:

[ ] This authorization is to be used for our own use, and Capital Heart Associates will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

[ ] The patient understands that Capital Heart Associates may receive financial gain as a result of disclosing this information due to ____

[ ] This authorization permits Capital Heart Associates to send the protected health information ONLY to these persons and to these addresses/fax numbers:

____

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____

____

ANY OTHER ADDRESS OR FAX NUMBER IS NOT PERMITTED BY THIS AUTHORIZATION

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization or, if applicable, during a contestability period. In order for the revocation of this authorization to be effective, Capital Heart Associates must receive the revocation in writing. All revocations must be sent to Capital Heart Associates to the attention of the Privacy Officer and are not effective until received by the Privacy Officer. The revocation must include:

- The patient's name, address, and patient number
- The effective date of this authorization and the recipients of the protected health information according to this authorization
- The patient's desire to revoke this authorization
- The date of the revocation and the patient's signature

Capital Heart will accept written revocations of this authorization via Certified US mail or fax at 919-881-0887.

This authorization will expire 180 days from the date of signing unless indicated otherwise. After this date, Capital Heart Associates can no longer use or disclose the patient's protected health information without first obtaining a new authorization form. Additional date of expiration: ____________________

I fully understand and accept the terms of this authorization.

Patient Signature ____ Date ____________________
Printed Name ____

FOR OFFICE USE ONLY

Authorization added to the patient's medical records on ____
Authorization verified by____ on __________________________

Patient name____ Medical Record Number_______________