New York Cardiology Associates P.C.

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Authorization to Use or Disclose My Health Information

Patient name: _____ **Date of birth:** _____

Address: _____ **Phone Number :** _____

I. My Authorization

You may use or disclose the following health care information (check all that apply):

☐ All my health information maintained by _____

☐ My health information relating to the following treatment or condition: _____

☐ My health information for the date(s): _____

☐ Other: _____

You may disclose this health information to:

Name (or title) and organization _____

Address: _____ City _____ State _____ Zip _____

Phone Number: _____ Fax Number: _____

Reason(s) for this authorization (check all that apply):

☐ for my personal records
☐ for another health care provider
☐ changing health care provider
☐ other: _____

This authorization ends: ☐ on (date) _____
☐ when the following event occurs _____

II. My Rights

I understand I do not have to sign this authorization in order to get health care benefits (treatment, payment or enrollment). However, I do have to sign an authorization form to receive health care when the purpose is to create health information for a third party.

Once the office discloses health information, the person or organization that receives it may re-disclose it. Privacy laws may no longer protect it.

_____ _____ _____
Patient or legally authorized individual signature **Date** **Witness**

_____ _____
Printed Name if signed on behalf of the patient **Relationship (parent, legal guardian, personal representative, etc.)**