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: _____

Other: _____

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 take part in a research study.
or
. 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 authotized individual signature | Date | Witness

_____ _____
Patient Name if signed on behalf of the Patient | Relationship (Parent, legal guardian, personal representative, etc.)

_____
Printed Name of legally authorized individual (if any)

FOR OFFICE USE ONLY

_____ _____
Provider's Signature | Date