



Peninsula Cardiology Associates, P.A.

☐ 400 Eastern Shore Drive, Salisbury, MD 21804 Tel: (410) 749-8906, Fax: (410) 749-4756
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Authorization for Use and Disclosure of Health Information

PATIENT NAME (<i>First, Middle, Last</i>)		DATE OF BIRTH (<i>MM, DD, YYYY</i>)
ADDRESS (Street, City, State, Zip Code)		
TELEPHONE	CELL PHONE	SOCIAL SECURITY NUMBER XXX-XX-_____

* I request that my Protected Health Information (PHI) from _____ be disclosed to:

RECIPIENT NAME:
ADDRESS (Street, City, State, Zip Code)
FAX (Healthcare provider only):

I authorize the following PHI to be released from my medical record:

- | | |
|---|---|
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Consultation Reports Date: _____ |
| <input type="checkbox"/> History and Physical | <input type="checkbox"/> Radiology Report Date: _____ |
| <input type="checkbox"/> Operative Report | <input type="checkbox"/> Laboratory Report Date: _____ |
| <input type="checkbox"/> Test Results Date: _____ Type: _____ | <input type="checkbox"/> EKG Report Date: _____ |
| <input type="checkbox"/> Emergency Room Record Date: _____ | <input type="checkbox"/> Billing Statements Date: _____ |
| <input type="checkbox"/> Abstract (<i>Patient Demographics, Discharge Summary, History & Physical, Operative/Procedure Note, Labs, Radiology and Pathology</i>) | |

Covering period of healthcare from _____ to _____ 2014.

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment of alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, please indicate if you would like this information released.

- | | | | |
|---|------------------------------|-----------------------------|--------------|
| Alcohol, Drug, or Substance Abuse Records | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dates: _____ |
| HIV Testing and Results | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dates: _____ |
| Mental Health or Psychotherapy Records: | <input type="checkbox"/> Yes | <input type="checkbox"/> No | Dates: _____ |

Purpose for requesting information:				
<input type="checkbox"/> Legal	<input type="checkbox"/> Insurance	<input type="checkbox"/> Personal	<input type="checkbox"/> Continuation of Care	<input type="checkbox"/> Transferring Care to Another Cardiology Practice

By signing this authorization form, I understand that:

- Requests for copies of medical records are subject to reproduction fees in accordance with federal/state regulations.
- I have the right to revoke this authorization at any time. Revocation must be made in writing and presented or mailed to Supervisor, Front Office, Peninsula Cardiology Associates, P.A. 400 Eastern Shore Drive, Salisbury, MD 21804. Revocation will not apply to information that has already been disclosed in response to this authorization.
- Unless otherwise revoked, this authorization will **expire on the following date/event/condition:** _____
- If I fail to specify an expiration date/event/condition, this authorization will expire one year from the date signed.
- Treatment, payment, enrollment or eligibility for benefits may not be conditioned on whether I sign this authorization.
- Any disclosure of information carries with it the potential for unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

I certify that I have read the provisions set forth in this authorization. I understand and agree to its terms.

_____/_____/_____ (Signature of Patient)	_____/_____/_____ (Date)	_____/_____/_____ (Signature of Witness)	_____/_____/_____ (Date)
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