Prairie
CARDIOVASCULAR CONSULTANTS, LTD.

Authorization to Use and/or Disclose Protected Information

I authorize ____
(Prairie Cardiovascular Consultants or other facility)

to use and/or disclose a copy of the specific medical information identified below for:

________________________________ ____________________
(Patient Name) (DOB)

XXX-XX-__________
(Last 4 digits of Social Security #)

Release my Medical Records to:

____
(Recipient Name)

____
(Recipient Address)

____
(address continued)

______________________ ______________________
(Recipient Phone #) (Recipient Fax #)

If you have an upcoming appointment, please provide the scheduled date: ____________

The purpose(s) of this disclosure:

- ☐ Personal Use
- ☐ Judicial Proceedings
- ☐ Continued Care / Treatment
- ☐ Other (Must Specify)______________

Dates of service requesting:

From______________ to ______________

I specifically authorize the use and/or disclosure of the following health information:

- ☐ Discharge Summary
- ☐ History and Physical
- ☐ Consultations
- ☐ EKG
- ☐ Cath Lab Data
- ☐ Carotid/ABI
- ☐ Holter Monitors
- ☐ Echocardiograms
- ☐ Nuclear Stress tests/Treadmills
- ☐ Operative Report
- ☐ Clinic Notes
- ☐ Device Reports (typed)
- ☐ Laboratory/Pathology
- ☐ X-ray
- ☐ Entire Medical Record
- ☐ Other (Must Specify)

____

____

I understand the information to be released may include records related to HIV/AIDS, Mental Health, Drug/Alcohol Abuse, STDs, Developmental Disabilities and Genetic Testing results. ***If your authorization to the release of these records is restricted, please write the restrictions below.***

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I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the HIPAA Office. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _________________(no longer than 1 year) If I fail to specify an expiration date, event or condition, this authorization will expire in 60 days.

I understand that authorizing the disclosure of this health information is voluntary. I understand that I may inspect or copy the information to be used or disclosed as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by Federal confidentiality rules. I also understand I may receive copies that were originated at another facility. If I have questions about disclosure of my health information, I can contact the HIPAA Office.

I further understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits.

Please allow approximately 2-3 weeks for record delivery.

______________________________________ ____________________
Signature of Patient or Patient's Representative Date

______________________________________ ____________________
Witness Date

______________________________________ ____________________
Print Name of Patient or Patient's Representative Relationship to Patient

Provide a copy with records.