Prairie Cardiovascular
The Doctors of Prairie

Authorization to Use and/or Disclose Protected Information

I authorize Prairie Cardiovascular
(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 Record to:

_____
(Name of Healthcare Facility, Individual, or Agency, etc.)

_____
(Address/City/State/Zip Code

_____ _____
(Recipient Phone #) (Recipient Fax #)

☐ Fax to number above ☐ Mail to address above ☐ Email to address below

☐ **E-mail to:**_____

If the e-mail address is shared with another person or the e-mail password is known to others, consider other methods of delivery.

Prairie Cardiovascular Consultants (PCC) will automatically send e-mail through encrypted/secured means unless otherwise directed. Unencrypted email poses some level of risk, e.g. a third party could see the information without consent. PCC is not responsible for unauthorized access to unencrypted email containing confidential information or any risk (e.g., virus) potentially introduced to the computer/device utilized when receiving/viewing confidential information in unencrypted electronic format or e-mail.

By selecting the unencrypted e-mail option I acknowledge the risks have been communicated and I accept these risks. ☐ Unencrypted Email.

The purpose(s) of this disclosure is:

☐ Continuing Care ☐ Personal Use
☐ Insurance Claim ☐ FMLA ☐ Disability
☐ Judicial Proceedings ☐ Other: _____

Date(s) of Information to be disclosed: From _____ **to** _____
Month/Year **Month/Year**
(NOTE: Future dates will not be honored.)

IF LEFT BLANK, ONLY INFORMATION FROM THE PAST TWO (2) YEARS WILL BE DISCLOSED.

SPECIFIC RECORDS TO BE RELEASED:
(CDs and images must be requested from the facility where the procedure was performed)

☐ Discharge Summary
☐ History and Physical
☐ Consultations
☐ EKG
☐ Cath Lab / EP
☐ Carotid/ABI
☐ Holter / Event Monitors
☐ Echocardiograms
☐ Nuclear Stress tests/Treadmills
☐ Operative Report
☐ Clinic Notes
☐ Laboratory/Pathology
☐ X-ray
☐ FMLA/Disability Form
☐ Entire Medical Record
☐ Other (Must Specify)
_____
_____

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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.***

_____

_____

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 up to 30 days for record delivery.

If the purpose of treatment is for *continuing care* please provide the date of your upcoming appointment with new provider:

_____
(**appointment date**)

_____ _____
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.

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