

PATIENT AUTHORIZATION FOR DISCLOSURE OF PROTECTED HEALTH INFORMATION

1. I authorize Heart Specialists of Ohio, Inc. to use or disclose the following information from my medical record:
 - My entire medical record
 - My medical records dated from _____ to _____
 - Protected Health Information relating to _____
(Specify diagnosis, procedure, condition, injury, etc.)
 - Other (please explain): _____

2. I authorize Heart Specialists of Ohio, Inc. to disclose Protected Health Information to: _____

Address: _____ City: _____ State: _____ Zip: _____
Telephone: _____ Fax: _____

3. Disclosure of Protected Health Information is being made for the purpose(s) of:
 - At the request of the patient or patient's legal representative
 - Permission to return to work, sick note, or medical excuse
 - Research study (please specify): _____
 - Insurance enrollment or coverage
 - Life insurance, automobile insurance or disability insurance claim
 - Employment purpose (please specify): _____
 - To respond to a subpoena
 - Other (please specify): _____

4. Authorization for disclosure of this Protected Health Information will expire on:
 - Please specify date: _____
 - Please specify event, if not a specific date: _____
 - Adjudication of claim
 - End of Research study

5. I understand that if the person or entity to whom Heart Specialists of Ohio, Inc. is disclosing information is not a doctor, health care provider or group health plan, then the information is no longer protected by HIPAA, and that person may use or disclose that information to other non-covered entities.

6. I understand that my refusal to sign this Authorization will not affect my ability to obtain treatment from Heart Specialists of Ohio, Inc. It may affect my ability to return to work or receive an employee or insurance benefit.

7. I understand I have the right to inspect or copy information disclosed by this Authorization.

8. I understand I may revoke this Authorization at any time. Revocation must be in writing. Heart Specialists of Ohio, Inc. cannot be held responsible for having disclosed information in reliance of this Authorization before it receives a written revocation.

9. I understand that Heart Specialists of Ohio, Inc., its physicians, and employees are released from legal responsibility or liability for disclosing protected health information authorized by my signature below.

10. I acknowledge I had an opportunity to ask questions before I signed and that I received a copy of the signed Authorization.

Print Name of Patient/Participant/Legal Representative

Date: _____

Signature