Premier Heart and Vascular Center
Your Heart Matters

Authorization and Uses for Disclosure of Protected Health Information

- Federal law says that we cannot share your health information without your permission except in certain situations. If you sign this form, you are giving us permission to share your health information with the person you have indicated below.
- This authorization is voluntary.
- Right to revoke: If you decide you do not us to share your health information any longer, sign the revocation at the end of this form and give this form to the front desk. If we have shared your health information for a research study, we may continue to use or share your health information for that purpose only.
- Payment, enrollment, or eligibility for benefits for your health care will not be affected if you do not sign this authorization, unless the disclosure is for eligibility or enrollment determinations, or for risk determinations.
- We cannot promise that the person you permit us to share your health information with will not share your health information with someone else you may not want to have your health information.
- You can keep a copy of this authorization, and can contact our Privacy Officer to get a copy if you do not have one.

Patient Last Name: _____First Name: _____Middle: _____
Nickname: _____
DOB: _____

I authorize **Premier Heart and Vascular Center** to share my health information with:

Practice or Individual/Name		
Address		
City/State/Zip		
Phone		

My health information may be used for the purpose of:

	Physician Referral		Legal
	Personal		Continuity of Care
	Insurance		Other

Explain other:

	Entire medical record		Diagnostic films/reports		Lab reports
	One year of history		Discharge summary		Hospital/operative reports
	Three year history		Hospital records		Prescription history
	Standard chart copy		Imaging/X-ray report		Accounting reports/ stmts
	Other:				

The following sensitive information must be specifically initialed to be included:

	HIV/AIDS related records		Behavioral health services or psychiatric care
	HBV or TB related records		Domestic violence
	Other communicable disease		Drug or alcohol diagnosis/treatment*
	Genetic information/testing		

I request that the following health information be shared:

*Federal regulations require a description of what kind of information and how much is to be disclosed. Explain:_____.

I understand that, if a person or entity that receives my personal health information is not a health care provider or health plan the information described above may be re-disclosed and no longer protected by the HIPAA Privacy regulations. However, the recipient is prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

The person I am authorizing to use and/or disclose the information may not receive compensation for doing so.

I also understand that I may refuse to sign this authorization and my refusal to sign will not affect my capacity to obtain treatment or payment of eligible benefits.

This authorization will expire on_____, unless otherwise revoked. If this date is left blank, this authorization will automatically expire in one year from the above date.

This form must be signed by EITHER the patient OR by the personal representative. The patient's parent may sign for the patient if the patient is a minor.

Signature of Patient: _____ Date: _____

If this form is signed by the personal representative, please include a copy of the document naming the personal representative, for example, a Power of Attorney, Personal Representative Designation form, or order appointing a guardian or executor.

Signature of Personal Representative: _____ Date: _____

Relationship to Patient: _____