



AUTHORIZATION TO DISCLOSE
HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

1. I authorize the release of medical records and disclosure of my health information by

Hamilton Cardiology Associates to: _____

Reason for disclosure: _____

2. The type of information to be disclosed is as follows: (include dates where appropriate)

- entire Hamilton Cardiology medical record
- all Hamilton Cardiology medical records from (date) _____ to (date) _____
- other _____

3. 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 for alcohol and drug abuse. THIS INFORMATION WILL ALSO BE RELEASED UNLESS I INITIAL HERE; I DO NOT AUTHORIZE RELEASE OF THIS INFORMATION _____

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the privacy officer of Hamilton Cardiology Associates. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand 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: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one (1) year.

5. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

A photocopy of this authorization shall be considered as effective and valid as the original.

Signature of patient or legal representative

Date

Printed Name of above signature

Relationship to Patient, if applicable