AUTHORIZATION FOR RELEASE OF INFORMATION

As required by the Health Insurance Portability and Accountability Act of 1996 Advanced Cardiovascular Specialists may not use or disclose your protected hea information except as provided in our Notice of Privacy Practices without your authorization. Your signature on this form indicates that you are giving your permission for the use and disclosure described herein. You may revoke this authorization at any time by signing and dating the revocation section on this form.

Patient Medical Record #
Date of Birth:
Home Phone:

Patient Name:
Social Security #:
Patient Cell Phone:

I hereby authorize Advanced Cardiovascular Specialists to release my information to or obtain information from: _____

_____

Information to be released:

Please check: Type of Report	Name of Report	Date of Report
_____ Progress Note	_____	_____
_____ Hospital Procedure	_____	_____
_____ Ultrasound	_____	_____
_____ Nuclear Medicine	_____	_____
_____ Vascular	_____	_____
_____ Arrhythmia Clinic	_____	_____
_____ Lab	_____	_____
_____ Other	_____	_____

Please check: Purpose of Disclosure

_____ Disability _____ Insurance Application _____ Workers Comp _____ Second Opinion _____ Legal

_____ Changing Physicians _____ Other (Please Specify):_____

1. I understand that this authorization may only be used for the disclosure listed above, and that the authorization will expire in one month after the date of the date of the authorization and that the form itself is kept as a part of my medical record for a minimum of six years.
2. I understand that I may revoke this authorization at any time by notifying Advanced Cardiovascular Specialists in writing, and that it will be effective on the date notified except to the extent action has already been taken.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by Federal privacy regulations.
4. I understand that if I choose to not authorize this release of information, my health care and payment for my health care will not be affected.
5. I understand that I may see and copy the records described on this authorization if requested, and I may receive a copy of this authorization upon request.
6. I understand that Advanced Cardiovascular Specialists may receive compensation for the use or disclosure listed above. There is no charge for records if copies are sent to facilities for ongoing care or followup treatment.

_____

PATIENT SIGNATURE DATE

_____

RECORDS DISCLOSED BY (AUTHORIZED PERSONNEL ONLY) DATE

REVOCATION SECTION

I hereby revoke this authorization.

_____

PATIENT SIGNATURE DATE

Medical Records Fax #(318)795-4656
Advanced Cardiovascular Specialists
PO Box 51008 Shreveport, LA 71135-1008