SOUTHERN CARDIOVASCULAR ASSOCIATES, PC

1026 GOODYEAR AVENUE
SUITE 200
GADSDEN, AL 35903
(256) 492-9924
FAX (256) 492-9965

PROTECTED HEALTH INFORMATION RELEASE AUTHORIZATION

Full Name _____ Date of Birth _____

Social Security Number _____

This will authorize _____ to use or disclose my protected health information to _____

As described below for the following purpose: _____

_____

_____

☐ Complete copy of medical record
☐ Psychotherapy Notes Only (If applicable, No other information may be included in Authorization)

Other (describe) _____

_____

_____

_____

Dates of care included _____ to _____

The information authorized for disclosure may relate to:

☐ Mental Illness (excluding psychotherapy notes)
☐ Drug or alcohol treatment (further disclosure prohibited or governed by 42 CFR Part 2)
☐ HIV related illness
☐ AIDS

I understand that I may inspect or copy the protected health information described by this authorization.

I understand that this authorization may be revoked in writing and delivered to Southern Cardiovascular Associates, P.C. at any time, although revocation will not be effective as to the disclosure of records whose release I have previously authorized, or where other action has been taken in reliance on an authorization I have signed.

I understand that information used or disclosed pursuant to this authorization could be disclosed to another party by the recipient and, if so, may not be subject to federal or state law protecting its confidentiality.

I understand that Southern Cardiovascular Associates shall not condition treatment, payment or eligibility for benefits on my providing authorization for the requested use or disclosure AND THAT I MAY REFUSE TO SIGN THIS AUTHORIZATION.

I understand that Southern Cardiovascular Associates shall have the opportunity to obtain direct or indirect remuneration as a result of this authorization.

_____ _____

Date Signature of individual or representative

_____

Authority or relationship of representative

EXPIRATION DATE: This authorization will expire on (date or event) _____ .
(If no date or event is stated, expiration is six months from the date it was signed.)

Southern Cardiovascular Associates shall provide a copy of this authorization, when signed, to the subject individual.