Patient Authorization to Use or Disclose Protected Health Information

I, * _____, understand ***Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.*** is authorized by me to use or disclose my protected health information (PHI) for a purpose other than treatment, payment or healthcare operations. I have read this authorization and understand what information will be used or discloses, who may use and disclose the information and the recipient(s) of that information. I specifically authorize any current employee or owner of ***Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.,*** or any other individual listed below to disclose my PHI as described on this form to the recipients listed below.

Description of the information to be used or disclosed (*check all that apply*):

- ☐ The patient's entire medical record (NOTE: This requires and explanation why the entire record may be disclosed)
- ☐ The patient's demographic information (*check all that apply*):
  ☐Name ☐Address ☐State/Zip Code only ☐Telephone ☐Age ☐Gender ☐Race
  ☐ ALL boxes checked above
- ☐ Medical Data/Information as related to:
  ☐Specific condition(s) ☐Specific professional service(s) ☐Specific medication(s)

Name(s) or class of person(s) other than current employees or owner(s) authorized by this form to use and disclose the patient's PHI: ***Social Security, Disability Determination, insurance companies, billing companies, referring physician(s), hospital(s)***

Name(s) or class of person(s) authorized by this form who may use and disclose the patient's PHI: ***Referring or consulting physician(s) and hospital(s)***

Purpose(s) of the information: ***Release of medical records and patient demographics for Disability Determination, referral, insurance and billing purpose.***

[X] *(Check if applicable)* This authorization is to be used for our own use, and ***Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.*** will not condition treatment or payment on this authorization. Moreover, the patient has a right to inspect or copy the information to be used or disclosed and may refuse to sign this authorization.

[X] *(Check if applicable)* The patient understands that ***Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.*** may receive financial gain as a result of disclosing this information due to billing insurance companies/Medicare/Medicaid.

* [ ] *(Check if applicable)* This authorization permits ***Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.*** to send the PHI information ONLY to this address or fax number:

_____

_____

Any other address or fax number is not permitted by this authorization.

The patient has a right to revoke this authorization in writing, except to the extent that action has been taken in reliance on this authorization of, if applicable, during a contestability period. In order for the revocation of this authorization to be effective ***Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.*** must receive the revocation in writing. The revocation must include:

- The patient's name, addr and patient number, if applicable,
- The effective date of this authorization, and the recipients of the PHI according to this authorization,
- The patient's desire to revoke this authorization, and
- The date of the revocation, and the patient's signature.

Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D. will accept written revocations of this authorization via: [X] Certified U.S. Mail

All revocations must be sent to ***Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.*** to the attention of the Privacy Officer, Kevin Marcantel, and are not effective until received by the Privacy Officer.

This authorization shall not expire for life, unless patient informed. After this date, ***Cardiovascular Diagnostic Center, APMC- Virginia Y. Gonzalez, M.D.*** can no longer use or disclose the patient's PHI without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

* _____ * _____

Patient Signature Date

FOR OFFICE USE ONLY

Authorization added to the patient's medical record on _____.

Authorization verified by _____ on _____.

Acknowledgement of Receipt of Privacy Notice

I have been presented with a copy of ***Cardiovascular Diagnostic Center, APMC's Notice of Privacy Practices,*** detailing how my information may be used and disclosed as permitted under federal and state law. I understand the contents of the Notice. Further I permit a copy of this authorization to be used in place of the original, and request payment of medical insurance benefits either to myself or to the party who accepts assignment. Regulations pertaining to medical assignment of benefits apply.

Signed: _____ **Date:** _____

If not signed by the patient, please indicate relationship to patient (e.g., spouse)

Relationship: _____ **Witness by:** _____

Internal Use Only:

If patient or patient's representative refuses to sign acknowledgement of receipt of notice, please document the date and time the notice was presented to patient and sign below.

Presented on (date and time): _____

By (name and title): _____