CULLMAN
REGIONAL

Cardiology Clinic
1912 Alabama Hwy 157
Cullman, AL 35058
256-737-2095 (Main Number)
256-737-2097 (Fax Number)

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CARDIOLOGY CLINIC

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I authorize release of my protected health information to the Receiving Facility by the Releasing Facility as indicated below:

TO: (Receiving Facility)	From: (Releasing Facility)
Facility Name: Cardiology Clinic	Facility Name: _____
Attention: Medical Records	Attention: _____
Address: 1912 Alabama Highway 157	Address: _____
City: Cullman	City: _____
State AL Zip: 35056	State: _____ Zip: _____
Office #: 256-737-2095 Fax#: 256-737-2097	Office #: _____ Fax #: _____

Please release the following medical/health information:

Patient Name: _____ DOB: _____

Patient Address: _____

City: _____ State: _____ ZIP: _____

Social Security Number (last 4 digits) _____ Telephone # _____

Identification of Patient or Personal Representative:

The patient or personal representative must present proof of identification by providing one of the following:
_____Photo Identification _____Birth certificate _____Executor or Admin _____Power Attorney

If you are signing as the personal representative of the patient, you may be asked to submit proof of your authority to act as a personal representative by the Releasing Facility. If Cardiology Clinic is the Releasing Facility and if the patient is **deceased**, a copy of the death certificate and/or proof of executor/administrator must be present before medical/health information is released.

Please provide the purpose for this use/disclosure of your medical/health information:

_____Patient/Personal Rep _____Legal _____Insurance _____Other, please specify

_____

Information to be released:

_____Discharge Summary	_____Emergency Room Record	____Face Sheet	_____History and Physical
_____Laboratory Reports	_____Operative Reports	____Pathology Report	_____Entire Medical Record
_____Radiology (x-rays) **	_____Imaging CD	____HIV/AIDS	_____Emergency Requested Info
_____UB/Acct'g Info***	_____Other, If other, please specify: _____		

____ **(Initial if requesting**) I understand that if the material disclosed contains data related to alcohol and/or drug abuse, the information has been disclosed from records whose confidentiality is protected by federal law. Federal regulations (42 CFR Part 2) prohibits making any further disclosure without the specific written consent of the person to whom the information pertains, or as otherwise permitted by such regulations.

____**(Initial if requesting)** I understand that the information is my health record may include information relating to sexually transmitted diseases.

I understand that if the person or entity that receives my medical/health information is not a health care provider, healthcare clearinghouse or health plan covered by federal privacy regulations that the information used or disclosed according to this authorization may be re-disclosed by the recipient and may no longer be protected by applicable federal or state privacy laws.

I understand that according to state and federal law I may be charged a reasonable fee for the photocopying of the requested medical/health information.

I understand I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment.

I understand I may revoke this authorization in writing at any time by submitting my revocation to the releasing hospital/provider except to the extent that they have taken reliance on this authorization. In this instance, I understand that the Releasing Facility may require that I send my written authorization to a different address than the Releasing Facility's address listed above. If the Releasing Facility is the Cardiology Clinic, I may revoke this authorization in writing by submitting my authorization to the Cardiology Clinic Director of Medical Records at the address listed above for Cardiology Clinic. This authorization will expire within 90 days if no expiration date is written.

I understand that protected health information will be released as described herein unless otherwise prohibited.

I hereby release the hospital/provider from any liability related to the release of this information to the persons or entities described herein.

If Cardiology Clinic is the Releasing Facility, I understand that if I am requesting protected health information for an incapacitated patient, my signature certifies that the patient is indeed incapacitated i.e. unable to appear in person for authorization of release of protected health information.

Signature of the patient:_____

Signature of personal representative:_____

Authority of personal representative: _____

Signature of Witness: _____

Date of Authorization:_____Expiration Date/Event: _____

(This authorization will expire in 90 days)