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# Authorization to Discuss Medical Information

I hereby authorize **Cardiovascular Specialists (CSONJ)/Holy Name Cardiology Associates (HNCA), PC and its staff** to use or disclose the specific information described below, only for the purposes and parties also described below. (*If more than one person is listed, please fill out one for each authorized person)*

Description of the specific information to be discussed:

___Appointment Date/Times ___Diagnosis ___ X-ray Results ___Medications

___Lab Tests/Results ____ Summary of Medical Record ___Care Plan

___ Other (specify): ______________________________________________________

**Indicate Confidential Information:** ____Mental Health ___HIV information ____ Alcohol/Drug Information

Patient Name: ___________________________________________________________

Date of Birth: ___________________________________________________________

Information to be given to:

Name: ____________________________________________

Relationship: _____________

Address: __________________________________________

Phone: ___________________________________________

**This authorization shall remain in effect from the date signed below until (please check one):**

☐ (specify expiration date or event)

☐ NO EXPIRATION DATE

**I understand that:**

I may inspect or copy the protected health information to be used or disclosed.

I may revoke this authorization in writing by contacting your office, attention Office Manager.

This authorization is giving **CSONJ/HNCA and its staff** the right to discuss my medical information with the one or more people listed above.

Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer be protected by the HIPAA.

I may refuse to sign this authorization and you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research-related treatment, in which case you may refuse to provide that research-related treatment).

Signature of Patient of Patient's Representative : _________________________________Date: ________

Relationship to Patient (If signed by personal representative of Patient): ______________________________

Practice Witness Printed Name : ______________________ Date: ___________________

Practice Witness Signature : ___________________________Date: _________________