

AUTHORIZATION TO USE AND DISCLOSE PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: ____/____/____

I authorize _____ to disclose a copy of my Protected Health Information to:

Recipient: _____

Address: _____

City: _____ State: _____ ZIP: _____

The specific health care information to be used/disclosed (include dates of service, if known):

The purpose of the disclosure is for _____

- A fee for processing this request may be charged.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure and no longer protected under federal law.
- I understand that treatment, reimbursement, enrollment in a health plan or eligibility for benefits may not be conditioned on signing this authorization.
- Questions regarding the disclosure of my medical information may be directed to Columbia Cardiology Privacy Official at (803) 744-4900.
- This authorization may be revoked in writing at any time except to the extent that Columbia Cardiology has previously taken action in reliance on this authorization. To revoke this authorization, please send a written statement and state that you are revoking this authorization to Columbia Cardiology Privacy Official, Post Office Box 4187, Columbia, SC, 29240.

This authorization expires one (1) year from the date of signature or shall remain in effect for the period reasonably needed to complete the request.

Signature: _____
Patient or Patient's Representative

Date

Personal Representative's Name/Authority (please print): _____