

Authorization For Release of Protected Health Information

Name: _____ Date of Birth: _____
Address: _____ Phone Number: _____

_____ Social Security No.: _____

I authorize the use or disclosure of my protected health information by EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. (“EASTERN CT CARDIOLOGY ASSOCIATES L.L.C.”) as specified below. I understand that signing this authorization is voluntary and that EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. may not require me to sign this authorization before EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. provides me with treatment.¹ I understand that I have the right to revoke this authorization at any time by providing a signed, written notice of such revocation to EASTERN CT CARDIOLOGY ASSOCIATES L.L.C.. I understand that a description of my right to revoke my authorization is set forth in EASTERN CT CARDIOLOGY ASSOCIATES L.L.C.’s Notice of Privacy Practices.

I understand that the information released pursuant to this authorization may no longer be protected by law or regulation and may be redisclosed by the recipient.

1)² a) Please use or disclose the following health information, if such

¹ **Conditional Authorization.** Replace the voluntary, unconditional language of the Authorization (second sentence) with the following language to create a new conditional authorization:

I understand that I must sign this authorization before EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. will provide me:

- Treatment related to research; or
- Services solely for the purpose of disclosure to a third party.

² **Psychotherapy Notes.** Replace Sections 1(a and b) regarding the information to be disclosed with the following Section to create a new separate Authorization for the use and disclosure of psychotherapy notes (Do not combine this with the conditional authorization language from Footnote 1):

Please release the following health information:

_____ Psychotherapy notes that are maintained separately from the rest of my medical record. Such notes have been recorded by a mental health professional as part of documenting or analyzing the contents of a conversation that took place during a private counseling session or a group, joint, or family counseling session.

information exists:

_____ The entire medical record (all information maintained by EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. for the time period indicated below); or

_____ The following limited health information

b) EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. cannot use or disclose certain information unless you specifically authorize such use or disclosure. Please initial next to each item below if you specifically authorize the release of health information relating to the testing, diagnosis or treatment for:

- _____ HIV/AIDS
- _____ Drug and alcohol abuse
- _____ Mental health/psychiatric disorders

2) Please specify the time period during which you wish the information described above to be disclosed:

All information maintained at any time by EASTERN CT CARDIOLOGY ASSOCIATES L.L.C., or

From: ____/____/____ To: ____/____/____

3) Please specify the individual(s) or entity(or entities) that may use or receive the information requested by this authorization:

4) Please specify the purpose(s) for which the information is being requested by this authorization:

- At the request of the individual requesting the information, or
- Other: _____

Unless earlier revoked, this authorization will expire on the following date:

___/___/___.

By signing below, I understand and acknowledge the following:

- I have read and understand this Authorization;
- I am authorizing EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. to use or disclose the health information to the person(s) and for the purpose(s) identified in this authorization; and
- If I have any questions about disclosure of my protected health information pursuant to this authorization, I may contact EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. Privacy Officer.
- ³

Print Name of Individual or Personal Representative

Signature of Individual or Personal Representative

Date

If signed by the individual's personal representative, describe the legal authority of the representative to act on behalf of the individual: _____

- Legal authority of representative verified by: _____

³ **Marketing Authorization.**

The health information is being requested by EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. for marketing purposes. EASTERN CT CARDIOLOGY ASSOCIATES L.L.C. [does/does not] receive financial or in-kind compensation in exchange for using or disclosing the information described above.