Patient Authorization to Use or Disclose Protected Health Information

I specifically authorize any current employee or owner of Advanced Cardiology, Inc. to release or disclose my protected health information to the entity named below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected health information.

Please Disclose to :

Name:			
Address:			
City:	State:	Zip:	Phone:

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

[ ] My/The patient's entire medical record

[ ] My/The patient's demographic information *(check all that apply)*:
[ ] Name [ ] Address [ ] State/Zip Code only [ ] Telephone
[ ] Age [ ] Gender [ ] Race [ ] Other: ____________________

[ ] Medical Data/Information as related to:
[ ] Specific condition(s): ____________________
[ ] Specific professional service(s): ____________________
[ ] Specific medication(s): ____________________
[ ] Other: ____________________

[ ] Other: ____________________

Information may be disclosed:

[ ] In writing *(photo copy provided)* [ ] Verbally

[ ] Via Fax at: *(Fax No.)*____________________

[ ] Via E-Mail at: *(E-Mail Address)*____________________
(Only if Advanced Cardiology, Inc., has capability)

Patient /Authorized Party *(signature)*____________________Date:______________

Please Print Name____________________