Hamilton Cardiology Associates

AUTHORIZATION TO DISCLOSE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____

1. I authorize the release of medical records and disclosure of my health information by:

_____

_____

_____

These records are to be disclosed to: **Hamilton Cardiology Associates,**
2073 Klockner Road
Hamilton New Jersey 08690
Phone: 609-584-1212 Fax: 609-_____
Reason for disclosure: the purposes of evaluation and treatment

2. The type of information to be used or disclosed is as follows: (include dates where appropriate)
[ ] entire medical record
[ ] all medical records from (date) _____ to (date) _____
[ ] other _____

3. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
THIS INFORMATION WILL ALSO BE RELEASED UNLESS I INITIAL HERE; I DO NOT AUTHORIZE RELEASE OF THIS INFORMATION_____

4. I understand I have the right to revoke this authorization at any time. I understand if I revoke this authorization I must do so in writing and present my written revocation to the privacy officer of the above-named medical care provider or facility authorized to make disclosure of my records. I understand the revocation will not apply to information that has already been released in response to this authorization. I understand the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date, event or condition, this authorization will expire in one (1) year.

5. I understand that authorizing the disclosure of this health information is voluntary. I need not sign this form in order to receive treatment. I understand I may inspect or copy the information to be used or disclosed. I understand any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.
A photocopy of this authorization shall be considered as effective and valid as the original.

_____ _____
Signature of patient or legal representative Date

_____ _____
Printed Name of above signature Relationship to Patient, if applicable