

Cardiovascular Surgery

ASSOCIATES

ADULT CARDIOTHORACIC VASCULAR SURGERY

AUTHORIZATION

FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

This Authorization authorizes the release of protected health information pursuant to 45 CFR Parts 160 and 164.

1. The undersigned authorizes the above-named provider Cardiovascular Surgery Associates to release information (describe specifically) _____
2. The information may be disclosed by employees or business associates of Cardiovascular Surgery Associates.
3. The information may be disclosed to: _____ (insert name or specific identification of the persons or entities to which the disclosure will be made)
4. The disclosure may be made for the following purpose _____ (describe specifically. If disclosure is at patient's request, "Patient request" will suffice.)
5. This authorization will expire on (date) _____ (or when describe occurrence)
6. I acknowledge: (i) that I have the right to revoke the authorization at any time, and (ii) that I understand that once this information is disclosed, it may no longer be protected by federal privacy law.

You may revoke this authorization only in writing sent by certified mail to Cardiovascular Surgery Associates at the address below. The revocation will be effective only upon receipt, except (1) to the extent Cardiovascular Surgery Associates has acted in reliance on the authorization, or (2) the authorization was obtained as a condition of obtaining insurance coverage and the insurer wishes to use the protected health information to lawfully contest the claim.

7. I understand that treatment by Cardiovascular Surgery Associates is not conditioned on my signing this authorization; although exceptions will be made for (a) research-related treatment, (b) for treatment the purpose of which is creating protected health information for a third party, such as pre-employment physical, and (c) except for psychotherapy notes, for health plans who condition enrollment or on an authorization request prior to enrollment or where payment is conditioned on an authorization to use PHI to deter.
8. If this authorization is for marketing use or disclosure of my information, Cardiovascular Surgery Associates:
 - 8.1 [] will be remunerated by a third party.
 - 8.2 [] will not be remunerated by a third party.

Date: _____

Signed by: _____

Print Patient's Name: _____

If person signing is other than patient, state authority under which signature is made: _____

(The patient must be given a copy of the authorization.)