
## AUTHORIZATION TO USE AND DISCLOSE HEALTH INFORMATION

This form is used to authorize the release of protected health information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 ("HIPAA").

Completion of this document authorizes the disclosure and/or use of health information about you. Failure to provide all information requested may invalidate this authorization.

**Patient Name:** _____
Last First Middle

**Home Address:** _____
_____

**Home Telephone:** _____ **Date of Birth:** _____

**USE AND DISCLOSURE:**

I hereby authorize Lawrence Derbes, M.D., Inc., whose trade name is Island Heart and Vascular (hereinafter, "Physician" or "Island Heart and Vascular"), to release my health information to: _____ _____. Address of the recipient or where my health information should be delivered:_____ _____.

**THE FOLLOWING INFORMATION IS TO BE RELEASED:**

☐ Assessment/History and Physical – Date(s) of Service: _____
☐ Discharge Summary – Date(s) of Service: _____
☐ Lab Tests – Date(s) of Service: _____
☐ Radiology Reports – Date(s) of Service: _____
☐ Entire Record
☐ Other (please specify needed information and date(s) of service, if known): _____
_____
☐ Mental health treatment information
☐ HIV test results
☐ Information about Genetic Testing
☐ Alcohol/drug treatment information

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**PURPOSE:**

The purpose of the release of this information is:
☐ Insurance or other third party reimbursement
☐ Continuity of medical care
☐ Pending legal action
☐ At the request of the patient
☐ Use by Employer or Employer's Insurance
☐ Other (please specify_____

**TERM:** This Authorization will remain in effect:

☐ Until I revoke it in writing.
☐ For six months from the date of this authorization.
☐ Until the following event occurs: _____
☐ Other: _____

I understand that the information in my medical 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. I understand that by signing this authorization, I am authorizing the release of such information unless specified otherwise above. _____ (please initial).

**RESTRICTIONS**:

According to federal and state law, if the medical information requested relates to AIDS/HIV treatment in a federally recognized chemical dependency unit, then the information will be accompanied by a statement limiting disclosure to third parties as required by law.

I understand that if the person or entity that receives the information is not a health care provider or a health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements.

I realize that Physician and his employees have a responsibility to maintain the confidentiality of the medical records in his possession. I understand that once the information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by federal privacy laws or regulations. Physician will not be held responsible for any subsequent disclosure by the recipient of the health information. I release Physician, and his employees of any liability that may arise as a result of any subsequent disclosure of my health information by the recipient.

**MY RIGHTS**:

I have the right to receive a copy of this Authorization.

I have the right to inspect and obtain a copy of the information to be disclosed.

I understand that I may refuse to sign or may revoke (at any time) this Authorization for any reason and that such refusal or revocation will not affect the commencement, continuation or quality of Physician's treatment of me; except, however, if my treatment is for the sole purpose of creating health information for disclosure to the recipient identified in this Authorization, in which case Physician may refuse to treat me if I do not sign this Authorization.

I understand that this Authorization will remain in effect until the term of this Authorization expires or I provide a written notice of revocation for this Authorization. The revocation will be effective immediately upon Physician's receipt of my written notice, except that the revocation will not have any effect on any action taken by Physician in reliance on this Authorization before he receives my written notice of revocation.

I have read and understand the terms of this Authorization, and I have had an opportunity to ask questions about the use and disclosure of my health information. By my signature below, I hereby, knowingly, and voluntarily, authorize the Practice to use or disclose my health information in the manner described above.

| Signature of Patient | Date | Signature of Witness* |
|---|---|---|

**Witness' Signature required for release of information about a mental illness or developmental disability*

Note: If patient is a minor or is otherwise unable to sign this Authorization, obtain the following signatures:

| Signature of Personal Representative | Relationship to Patient | Date | Witness* |
|---|---|---|---|

**Witness' Signature required for release of information about a mental illness or developmental disability*

NOTE: Any alteration or modification of this form will delay processing and provision of the requested protected health information.