AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION

____
Name of Patient

____
Birth Date

____
Street Address

____
City, State, Zip Code

I hereby authorize:

____
Name of Individual or Entity

____
Street Address

____
City, State, Zip Code

To disclose my protected health information, as described below, to:

Capital Cardiology Associates, PC
7 Southwoods Boulevard
Albany NY 12211

Check off information NOT to be released:

_____ Medical History, Examination Reports
_____ Treatment or Tests
_____ X-ray Reports
_____ Laboratory Reports
_____ HIV Test Results*
_____ Mental Health
_____ Sexually Transmitted Disease
_____ Alcoholism
_____ Surgical Reports
_____ Hospital Records Including Reports
_____ Developmental Disabilities
_____ Prescriptions
_____ Consultations
_____ Allergy Records
_____ Drug Abuse
_____ Other (please specify)________________

*A listing of the statutory exceptions to release HIV test results without consent is available

Purpose for Need of Disclosure
_____ At the request of the individual
____
____

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without obtaining my authorization.

I understand that I have the right to:

- **Receive Copy of This Authorization**
- **Refuse to Sign This Authorization** and that treatment, payment, enrollment in a health plan or eligibility for healthcare benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization**, except to the extent that the person(s) and/or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect for 10 years or until the following date(s): ________________

____
Signature of Patient (or Legal Representative)

____
Date

If signed by Legal Representative:

____
Relationship to Patient (authority to act on patient's behalf)

____
Date