**Upstate Cardiology**

*With All Our Heart We Care for Yours*

**RELEASE OF INFORMATION**

AUTHORIZATION FOR USE OF DISCLOSURE OF PROTECTED HEALTH INFORMATION\*

1. **AUTHORIZATION:**

I AUTHORIZE **UPSTATE CARDIOLOGY** TO USE AND DISCLOSE THE PROTECTED HEALTH INFORMATION DESCRIBED BELOW TO:

NAME OF PERSON RELATIONSHIP TO PATIENT

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1. **EFFECTIVE PERIOD:**

THIS AUTHORIZATION FOR RELEASE OF INFORMATION COVERS: **ALL PAST, PRESENT AND FUTURE MEDICAL HISTORY.**

1. **EXTENT OF AUTHORIZATION:**

I AUTHORIZE THE RELEASE OF MY COMPLETE HEALTH RECORD EXCEPT:

MENTAL HEALTH

ALCOHOL/DRUG ABUSE TREATMENT

COMMUNICABLE DISEASES (INCLUDING HIV AND AIDS)

OTHER (SPECIFY)

1. THIS MEDICAL INFORMATION MAY BE USED BY THE PERSON I AUTHORIZE TO RECEIVE THIS INFORMATION FOR MEDICAL TREATMENT OR CONSULTATION, BILLING OR CLAIMS PAYMENT, OR OTHER PURPOSES AS I MAY DIRECT.
2. THIS AUTHORIZATION SHALL BE IN FORCE UNTIL FURTHER NOTIFICATION FROM ME, THE PATIENT.
3. I UNDERSTAND THAT I HAVE THE RIGHT TO REVOKE THIS AUTHORIZATION, IN WRITING, AT ANY TIME. I UNDERSTAND THAT A REVOCATION IS NOT EFFECTIVE TO THE EXTENT THAT ANY PERSON OR ENTITY HAS ALREADY ACTED IN RELIANCE ON MY AUTHORIZATION OR IF MY AUTHORIZATION WAS OBTAINED AS A CONDITION OR OBTAINING INSURANCE COVERAGE AND THE INSURER HAS A LEGAL RIGHT TO CONSENT A CLAIM.
4. I UNDERSTAND THAT MY TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS WILL NOT BE CONDITIONED ON WHETHER I SIGN THIS AUTHORIZATION.
5. I UNDERSTAND THAT INFORMATION USED OR DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE DISCLOSED BY THE RECIPIENT AND MAY NO LONGER BE PROTECTED BY FEDERAL OR STATE LAW.

PRINT NAME: DATE:

SIGNATURE:

RELATIONSHIP TO PATIENT IF SIGNING FOR THE PATIENT:

\*REQUIRED BY THE HEALTH INSURANCE PORTABLILITY AND ACCOUNTABILITY ACT, 45 C.F.R. PARTS 160 AND 164