



Washington Heart Rhythm Associates, LLC

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Authorization for Disclosure of Health Information

Patient Name: _____

Date of Birth: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip: _____

1. ***I authorize the use or disclosure of the above named individual's health information as described below.***

2. ***The following individual or organization is authorized to make the disclosure:***

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

3. The type and amount of information to be used or disclosed is as follows: (include dates where appropriate).

_____ Complete health records

_____ Lab results/X-ray reports

_____ Physical exam

_____ Consultation reports

_____ Procedural reports

_____ Other (please specify): _____

4. 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.

5. ***This information may be disclosed to and used by the following individual or organization.***

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

For the purpose of: _____

6. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the office management. I understand that 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. This authorization shall be valid until _____. If no date given, the below applies.

If I fail to specify an expiration date, event or condition, this authorization will expire in ninety days. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR 164.524. If I revoke this authorization at any time, it will have no impact on uses or disclosures made while the authorization was valid.

I HAVE A RIGHT TO A COPY OF THIS AUTHORIZATION.

Copy requested: Yes No

Copy received: Yes No

Signature of patient or legal representative

Signature of witness

Date: _____

Date: _____