PATIENT AUTHORIZATION OF USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION (PHI)

I, _____, authorize Cardiology Associates of Morristown to use and/or disclose my protected health information to:

_____

The protected health information that can be used and/or disclosed includes:

_____

_____

_____

The purpose of this use or disclosure is:
At my request or _____

This authorization is in effect until this date:

_____

- I understand that I have the right to revoke this authorization at any time and must do so in writing. I must present this request to the Privacy Officer at CAM or its Designated Contact Person as detailed in CAM Privacy Plan.
- I understand that the revocation will not apply to PHI that has already disclosed in response to this authorization.
- I understand that the revocation will not apply to my insurance company when the provides my insurer with the right to contest a claim under my policy.
- I understand that any disclosure of my PHI carries with it the potential for redisclosure by the recipient and the PHI may not be protected by the federal privacy rules.

Signed: _____ Name: _____
(patient or patient representative)
Relationship to patient (if other than self) _____