Cardiology Associates
of Altoona, L.L.P.

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

I, _____, born on _____
authorize Cardiology Associates of Altoona, 1321 11th Avenue, Altoona, PA 16601 to provide
_____

With any information which may be requested regarding my physical condition and treatment rendered therefore and, if necessary, to allow them or my physician appointed by them to examine my records or x-rays taken of me regarding my physical condition or treatment.

Date needed by:_____Purpose of Disclosure: _____

GENERAL AUTHORIZATION: I understand and acknowledge that this general authorization allows the health care facility to release all or part of the records indicated above for the purpose stated. I understand that, on occasion, information may be released by telephone or fax.

SPECIAL AUTHORIZATION: I understand that my medical records may contain alcohol/drug abuse/Human Immune Virus/Acquired Immune Deficiency Syndrome and/or mental health information. I also give special authorization to the health care facility to release this information in my records to the person or organization named above for the stated purpose.

This consent is valid for 90 days unless revoked by me in writing before the release of the above designated information. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I may refuse to sign this authorization and that the designated information will not be disclosed. I understand my refusal to sign will not affect my treatment.

I have read this form or have had it read to me and understand it. I was given the opportunity to ask questions. Any questions that I asked were answered to my satisfaction.

My signature below indicated my voluntary authorization for both the general and special release of information.

_____ _____ _____ _____

Signature of Patient Date Signature of Witness Date

If the patient is unable to sign or is a minor, complete the following:
Patient is a minor_____years of age.
Patient is unable to sign because of_____ .

A second witness signature is required only when the patient is unable to give written consent:

_____ _____

Signature of Second Witness Date

_____ _____

Signature of Parent/Legal Guardian/Authorization Representative Date Relationship

This information has been disclosed to you from records protected by PA law. PA law prohibits you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person for whom it pertains or is authorized by the Confidentiality of HIV-Related Information Act. A general authorization for the release of medical or other information is not sufficient for this purpose. Revised: 08/21/2003