Patient Authorization to Use or Disclose Protected Health Information
HIPAA

I, ____, understand that Pacific Coast Cardiology is not authorized by me to use or disclose my protected health information for a purpose other than treatment, payment, or health care operations. In addition, I specifically authorize any current employee or owner of Pacific Coast Cardiology, to disclose my protected health information as described on this form to the recipients I have noted below. I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected health information.

Names of person(s) other than myself authorized by this form to obtain my protected health information (family members, etc) ____

____

____

Description of the information to be used or disclosed (check all that apply)

❏ Entire medical record.

<u>**OR**</u>

Demographic information (check all that apply)

- ❏ Name
- ❏ Address
- ❏ State/Zip Code only
- ❏ Telephone
- ❏ Age
- ❏ Gender
- ❏ Race
- ❏ Other: ❏ Medical Data / Information as related to
- ❏ Specific condition(s)
- ❏ Specific professional service(s)
- ❏ Specific medication(s) ____
- ❏ Other ____

  ____

I authorize Pacific Coast Cardiology and understand what information may be disclosed on my behalf to third parties.

Signature: ____ Date: ____

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