ATLANTA HEART SPECIALISTS, LLC

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Authorization for Disclosure of Health Information

Name Patient	Date of Birth	Phone Number	Medical Record Number

1. I hereby authorize Atlanta Heart Specialists, L.L.C. to: **(√ Check One)**
   _____ disclose information to OR _____ obtain information from

_____
(Name of Person or Organization)

_____
(Phone Number) (Fax Number

_____
(Address for above) or (**additiona**l Name of Person or Organization to be given authorization)

_____
(Phone Number) (Fax Number

2. This information is to be disclosed for the period(s) of healthcare:(date) _____ to (date)_____

Information To Be Disclosed (Please Check √)

_____ **Entire Record**	_____ X-Ray Reports	_____ Cardiac Cath Report
_____ Laboratory Tests	_____ Stress Test Report	_____ Office Notes
_____ EKG	_____ Echo Report	_____ Videotape, digital, or other

Other (please specify) _____

4. _____ (Patient's initials) I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric HIV testing, HIV results, or AIDS information.

5. I understand this authorization may be revoked by me in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire in 12 months following the date signed.

6. RESEARCH: Under certain circumstances, we may use and disclose medical information about you for research purposes. For example, a research project may involve comparing the health and recovery of all patients who received one medication to those who received another, for the same condition. All research projects are subject to a special approval process. This process evaluates a proposed research project and its use of medical information, trying to balance the research needs with patients' needs for privacy of their medical information. Before we use or disclose medical information for research, the project will have been approved through this approval process, but we may, however, disclose medical information about you to people preparing to conduct a research project, for example, to help them look for patients with specific medical needs, so long as the medical information they review does not leave Atlanta Heart Specialists, LLC. We will almost always ask for your specific permission if the researcher will have access to your name or other information that reveals who you are, or will be involved in your care at Atlanta Heart Specialists, LLC

7. I have been given a copy of the Atlanta Heart Specialists, LLC, HIPPA policy and E-Prescribe notification.

I, the undersigned, have read the above and authorize Atlanta Heart Specialists to disclose such information as herein contained. This office is released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I understand that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected.

_____ _____ _____
Date Signature of Patient or Legal Representative Relationship to Patient