The Arrhythmia Institute

Michael J. Rozengarten MD, FACC
Scott W. Burke MD, FACC
Rafael E. Peña MD, FACC
Eran S. Zacks MD, FACC

☐ Checked ID _____ (First initial, Last Name)

Authorization to Use or Disclose Health Information

Patient Name: _____ Phone #: _____

Date of Birth: _____ Medical Record #: _____

1. I authorize The Arrhythmia Institute to: ☐ Release information to: ☐ Obtain information from:

Individual or Facility: _____ Phone: _____

Address: _____ Fax: _____

2. The type of information to be used/disclosed: (check appropriate box(s) and include other information where indicated).

Date(s) of Service: _____

☐ Face Sheet / Registration Sheet / Referral Sheet	☐ Radiology Reports	☐ Discharge Summary
☐ EKG / Cardiology Testing Results	☐ ER Record	☐ Operative Report
☐ H&P	☐ Pathology Report	☐ Consults
☐ Medication List	☐ Progress Notes	☐ Lab Results

☐ Entire Record (does not include the Extra Protected info listed in Section #3)

☐ Other (please specify): _____

3. ☐ Behavioral Health Information _____ initial ☐ Substance Abuse Information _____ initial

☐ Sexual abuse/assault, domestic violence _____initial ☐ Human Immunodeficiency Virus (HIV) Info _____ initial

I understand if my authorization includes Behavioral Health, substance abuse or HIV information, it may include: (i) information concerning whether an individual has been the subject of a human immunodeficiency virus (HIV) – related test, has HIV, an HIV related illness, acquired immunodeficiency syndrome (AIDS), and/or including information pertaining to the individual's contact (Section 7100.133); (ii) substance abuse information in my health record may include whether or not I am receiving treatment, my prognosis, a brief description of my progress, and/or a short statement as to whether I have relapsed into substance abuse and the frequency of such relapse (PA Drug and alcohol abuse control act of 1972, act 148 Section 7(e); (iii) behavioral health information services (Mental Health Procedures act 1976, Section 5100.3-39).

4. Purpose of authorizing disclosure/to share with:

☐ Other healthcare provider ☐ Insurance ☐ Legal/Lawyer ☐ Other (please describe): _____

5. I understand

a. I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present to the medical record department. The revocation will not apply to information that has already been released in response to this authorization. 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;
b. Unless I specify differently, this authorization will expire six months from the date signed below;
c. Once the above information is disclosed, it may be re-disclosed by the recipient and the information may not be protected by Federal privacy laws or regulations;
d. The use or disclosure of my health information is voluntary except in accordance with Federal or State Law and any mandatory reporting requirements.

_____ _____ _____

Signature of Patient or Legal Representative Date Time

If signed by legal representative, relationship to patient _____

_____ _____ _____

Signature of Witness Date Time

A copy of this authorization form has been included with the copy of the medical record.

I have been offered a copy of this Authorization Form. Circle one and initial: Accept / Refuse - Initial _____