INTERVENTIONAL CARDIOLOGY
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HIPAA Release of Information Authorization Form

I, _____hereby authorize _____

to release to _____ my personal health information from the following dates: _____ to _____.

This includes everything except the following information about me:

_____.

I understand that any personal health information or other information released to the person or organization identified above may be subject to re-disclosure by such person/organization and may no longer be protected by applicable federal and state privacy laws.

This authorization is valid from the date of my signature below.

I understand that I have a right to revoke this authorization by providing written notice to *Apogee Medical Associates, PA* However, this authorization may not be revoked if *Apogee Medical Associates, PA* has acted on this authorization prior to receiving my written notice.

I also understand that I have a right to have a copy of this authorization. I further understand that this authorization is voluntary and that I may refuse to sign this authorization. My refusal to sign will not affect my eligibility for benefits or enrollment or payment for or coverage of services.

Name of Patient: _____

Signature of Patient: _____

Date: _____