

ELECTROPHYSIOLOGY AND PACING INTERVENTIONALISTS

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Authorization for Use or Disclosure of Information

I, _____ **Date of Birth:** _____ **SS#:** _____

hereby authorize E.P.I. to (check those that apply):

use the following protected health information and/or

disclose the following protected health information to _____

The following health information and dates of treatment to be used or disclosed, including, but not limited to:

Dates of Treatment: _____.

This protected health information is being used or disclosed for the following purposes:

- continuity of medical care
- research purposes including treatment
- release of information requested by physician and/or other entity

This authorization shall be in force and effect until all records requested are received by the above-mentioned party at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to E.P.I. I understand that a revocation is not effective to the extent that EPI has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

EPI will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I have been made aware of the practice's "Notice of Privacy Practices" and that statements included in this authorization are binding on the EPI.

I understand I have the right to:

- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to E.P.I. from a third party, if applicable.]

Signature of Patient or Personal Representative

Date

Name of Patient or Personal Representative

Description of Personal Representative