Practice Communication and Personal Representative Authorization Form

By completing this form you will be granting Metropolitan Cardiology Consultants permission to release your Protected Health Information (PHI) to one or more Personal Representatives and/or to communicate with you in certain ways. Only the information indicated below will be released to your Personal Representative and/or communicated to you in the manner specified. **This authorization is valid for _____ (---) years from the date of signature.**

PATIENT NAME:____________________ MEDICAL RECORD # ____________________

PATIENT ADDRESS: ____

PATIENT TELEPHONE: ____________________

PERSONAL REPRESENTATIVE DESIGNATION:

I REQUEST AND AUTHORIZE METROPOLITAN CARDIOLOGY CONSULTANTS TO DISCLOSE OR RELEASE MY PROTECTED HEALTH INFORMATION (PHI) TO:

NAME:____________________ RELATIONSHIP TO PATIENT:____________________

ADDRESS:____

THIS REQUEST AND AUTHORIZATION APPLIES TO: (Check all that apply)

☐ financial information ☐ health care information ☐ demographic information only (i.e., address changes etc.)

☐ sensitive health information (i.e., HIV/AIDS status) ☐ mental health records (i.e. payment, diagnosis, etc.)

☐ other, please specify:____

Communications Authorization: (Check and complete all that apply)

I HERBY AUTHORIZE METROPOLITAN CARDIOLOGY CONSULTANTS TO:

Leave Messages on my ☐ Home / ☐ Business Answering Machine which may contain my Protected Health Information (PHI).

☐ Contact ____________________ at the following phone #____________________ in case of an emergency or an urgent need to contact me about my care. I understand such contact may include release of Protected Health Information in that circumstance.

[Insert others]

I may withdraw this entire authorization or any part thereof at any time by submitting a written request to the Metropolitan Cardiology Consultants Privacy Official at ______________________________. If I do, I understand that my PHI may have already been released to my Personal Representative or used to communicate with me in the manner specified after I gave permission.

I have carefully read and understand the above and do herein expressly and voluntarily authorize disclosure of the above information about, or medical records of, my condition to those persons listed above and/or communication with me in the manner specified.

Patient's Signature: ______________________________

Date: ____________ **Authorization Expires ______(____) Years from Date of Signature**

ACKNOWLEDGEMENT*

I hereby acknowledge receipt of the Notice of Privacy Practices.

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Signature

____

Print Name

____

Date

* This acknowledgement reflects the proposed modifications to § 164.520 of the privacy standards as set forth by the Department of Health and Human Services at 67 Fed. Reg. 14814 (March 27, 2002). It applies to health care providers with direct treatment relationships. This acknowledgement, or some other form of acknowledgement (e.g., initials), can be on a cover sheet to be retained by the provider, on a separate list apart from the notice, or otherwise.