INTERNAL MEDICINE & CARDIOLOGY
BRONX MEDICAL-CARDIAC, PLLC.

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Authorization to use or disclose health information

Patient Name: _______________________________ Chart: __________________
Date of birth: ________________________

1. I authorize Bronx Medical Cardiac to disclose the above-named individual's identifiable health information as described below:
   ____ Entire record ____ consult of _______________ (date)
   ____ Diagnostic tests performed o___________________________ (date(s)
   ____ Other

I understand that the released information may be subject to re-disclosure by the recipients and no longer be protected by federal privacy regulations.

2. The information identified above may be used by or disclosed to the following sources:

   Name: ____
   Address: ____
   Name: ____
   Address: ____

3. I understand that this authorization will expire on ______/______/______. If I fail to specify an expiration date this authorization will expire 6 months from the date it was signed.

4. I understand that I may revoke this authorization at any time by notifying the providing organization in writing. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that 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.

5. I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment and the payment for my healthcare.

____ _______________
Signature of patient or legal representative Date

Relationship of legal representative to patient: _______________________________

Authority of representative to act for the patient: _______________________________