

Authorization for Release of Information

I hereby authorize the use or disclosure of my health information as described below.

Patient Name: _____

Date of Birth: _____

Please Identify person(s)/organization(s) authorized to use or disclose your information:

Please Identify person(s)/organization(s) authorized to receive your information:

Please provide a specific description of your information to be used or disclosed, including dates:

Please provide a statement describing each purpose for the requested use or disclosure of your information : _____

The patient or patient's representative must read and initial the following statements:

a) I understand that Pioneer Valley Cardiology will not condition my treatment and (if applicable), payment for my health care, my enrollment in a health plan, or eligibility for benefits on whether I provide authorization for the requested use or disclosure except in limited circumstance (e.g., if the treatment is research-related or the treatment is necessary for the purpose of creating Protected Health Information for disclosure to a third party, such as physical examinations for school, camo, and employment purposes).

Initials: _____

b) I understand that I may revoke this authorization at any time by notifying Pioneer Valley Cardiology in writing. However, such revocation does affect any actions taken by Pioneer Valley Cardiology before receiving the written revocation.

Initials: _____

c) I understand that the information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient any may no longer be protected by federal privacy regulations or the other applicable state or federal laws.

Initials: _____

d) I understand that I may see and copy the information described on this form is I ask for it and that I get a copy of this form after I sign it.

Initials: _____

e) I understand that this authorization will expire on _____
or expiration event: _____

Initials: _____

f) I understand that this authorization is voluntary and that I have the right to refuse to sign this authorization.

Initials: _____

Signature of individual or personal representative: _____

Date: _____

Printed name of personal representative: _____

Relationship of personal representative to individual: _____

Pioneer Valley Cardiology Representative: _____

Date: _____

Pioneer Valley Cardiology
2 Medical Center Drive
Suite 410/Suite 510
Springfield, MA 01107
P (413) 781-5735
F (413) 732-0225

Pioneer Valley Cardiology
299 Carew Street
Suite 310
Springfield, MA 01104
P (413) 732-1928
F (413) 734-1716

*** YOU MAY REFUSE TO SIGN THIS AUTHORIZATION**