# SOUTH DENVER CARDIOLOGY ASSOCIATES PC

**PATIENT AUTHORIZATION FOR USE, DISCLOSURE AND/OR REQUEST OF PROTECTED HEALTH INFORMATION**

By signing this authorization, I authorize South Denver Cardiology Associates PC to **use, disclose, and/or request**, certain protected health information (PHI) about me to/from:

_____

**Name of entity/entities to receive or requesting this information**

_____

**Address of entity/entities to receive/request information fax number phone number**

This authorization permits South Denver Cardiology Associates PC to use, disclose, and/or request the following individually identifiable health information about me (**specifically describe the information to be used or disclosed, such as date(s) of service, level of detail to be released, origin of information, etc.**)

_____

_____

The information will be used, disclosed, and/or requested for the following purpose:

_____

**(If requested by the patient, purpose may be listed as "At the request of the individual.")**

The purpose(s) is/are provided so that I can make an informed decision whether to allow release of the information. This authorization will expire on:

_____

**Expiration Date or Defined Event**

The practice ☐**will** ☐**will not** receive payment or other remuneration from a third party in exchange for using or disclosing the PHI.

I do not have to sign this authorization in order to receive treatment from South Denver Cardiology Associates PC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. **My written revocation must be submitted to the Privacy Official**:

**Brenda Lambert MBA, RNBC**
**c/o South Denver Cardiology Associates PC**
**South Denver Heart Center**
**1000 Southpark Drive**
**Littleton Colorado 80120**
**Phone: 303.744.1065 Fax: 303.733.1699**

_____ _____
Patient Name (Please print) Social Security Number

_____ _____AM/PM
Patient Signature Date Time

_____ _____
Name of Legal Guardian (Please print) Relationship to Patient

_____ _____
Legal Guardian Signature Patient's Date of Birth

***PATIENT / GUARDIAN TO BE PROVIDED WITH A SIGNED COPY OF AUTHORIZATION***