LAS SENDAS CARDIOLOGY

3514 N. POWER RD. #107 MESA, AZ 85215 PH 480-361-9949 FAX 480-361-9969

HIPAA Privacy Authorization Form:

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act ---- 45 CFR Parts 160 and 164)

1. I hereby authorize LAS SENDAS CARDIOLOGY to use and/or disclose the protected health information (‘‘PHI’’) described below to my agent or representative as identified in my durable power of attorney for health care named _____.

2. Authorization for release of PHI covering the past, present and future periods of health

3. I hereby authorize the release of PHI as follows (check one):

_COMPLETE HEALTH RECORDS. _MENTAL HEALTH CARE. _COMMUNICABLE DISEASES, HIV, AIDS

_ALCOHOL. _DRUG ABUSE. _OTHER (PLEASE SPECIFY)_____

4. In addition to the above, I also disclosure of information pertaining but not limited to my billing, condition, treatment and prognosis to the following:

NAME_____CELL#_____RELATIONSHIP_____

ADDRESS_____

NAME_____CELL#_____RELATIONSHIP_____

ADDRESS_____

5. This medical information may be used by the persons I authorize to receive this information for medical, consultation, treatment, billing or claims payment or other purposes as I may direct.

6. This authorization shall remain in effect until nine months after my death at which time this authorization will expire.

7. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

8. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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

PRINTED NAME_____

SIGNATURE_____ Date: _____