Cardio-Thoracic Surgeons, P.C.

Authorization for Use or Disclosure of Information

I, _____ DOB _____ hereby authorize Cardio-Thoracic Surgeons, P.C. (CTS) to obtain or disclose the following protected health information for the following dates.

_____ to _____

___ Entire Medical Record (All Information)

___ Clinic/Office / Chart Notes

___ Hospital Records

___ Laboratory reports

___ Diagnostic Testing

___ Other, _____

The protected Health Information is being disclosed to Dr. _____

Cardio-Thoracic Surgeons, P.C.
2871 Acton Road
Suite 100
Birmingham, Alabama 35243
Fax # 205-939-0242

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer at 2871 Acton Road, Suite 100, Birmingham, Alabama 35243. I understand that a revocation is not effective to the extent that my physician has relied on the use or disclosure of the protected health information, or if my authorization was obtaining insurance coverage and the insurer has a legal right to contest a claim. Cardio Thoracic Surgeons, P.C. will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure.

I understand I have the right to:

- Inspect or copy the health information to be used or disclosed as permitted under the law.
- Refuse to sign the authorization.

The use or disclosure requested under this authorization may result in financial gain to my physician from a third party. This authorization will expire on _____. After this date Cardio Thoracic Surgeons, P.C. can no longer disclose the patient's protected health information without first obtaining a new authorization form.

I fully understand and accept the terms of this authorization.

_____ _____

Signature of patient or patient's representative **Date**

Printed name of patient representative_____

Relationship to the patient: _____