

ACADEMIC HEART & VASCULAR PLLC

Beaumont Heart Center Clinic • 3601 W. 13 Mile Rd. • Royal Oak, MI 48073 • (248) 898.4163 phone • (248) 898.5596 fax
21090 Allen Rd. • Woodhaven, MI 48183 • (248) 898.4163 phone • (248) 898.5596 fax

Authorization For The Use and Disclosure of Protected Health Information

Patient Name/Address: _____ Date of Birth: _____

SSN: _____

By my signature below, I authorize the physicians and staff of Academic Heart & Vascular PLLC (AHV) to use and disclose my protected personal health information as follows:

1. Name and address of receiver of information: _____

2. Specific description of information to be used or disclosed is: _____

3. The purpose of this disclosure is: _____

4. This authorization will automatically expire after 6 months unless an expressed revocation is received, or will expire automatically on _____.
5. 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 of Academic Heart & Vascular PLLC (AHV). I understand that a revocation is not effective until received by AHV and is not effective to the extent that AHV has previously acted in reliance on this 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.
6. 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.
7. My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except: 1) if my treatment is related to research, or, 2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

I acknowledge that I have read and understand this authorization.

Signature of Patient or Personal Representative

Date

Print Name of Patient or Personal Representative

Description of Personal Representative's authority

Signature of Witness

Date

Sent by: _____ Date: _____