

FLORIDA HEART CLINIC

CHRISTIAN M. HEESCH, MD

Authorization for Florida Heart Clinic, LLC to Use or Disclose My Health Care Information

Patient Name: _____ Date of Birth: _____

I. My Authorization:

You may use or disclose the following health care information (check all that apply):

- All health care information in my medical record
- Health care information in my medical record relating to the following treatment or condition:

- Health care information in my medical record for the date(s): _____
- Other (e.g., X-rays, bills, labs), specify date(s): _____

You may use or disclose health care information regarding testing, diagnosis and treatment for (check all that apply):

- HIV (AIDS Virus)
- Sexually Transmitted Diseases
- Psychiatric Disorders/Mental Health
- Drug and/or Alcohol Use

You may disclose this information to: _____

Purpose(s) for this authorization (check all that apply):

- At my request
- Other(specify): _____

This authorization ends: (This document does not permit disclosure of health information created more than 90 days after the date it is signed.)

- In 90 days from the date signed
- On(date): _____
- When the following event occurs: _____

(No longer than 90 days from date signed)

II. My Rights

I understand that Dr. Heesch may not base treatment or payment decisions on whether or not I sign this authorization.

I understand I have the right to inspect or receive a copy of my protected health information and to receive a copy of this signed form.

I acknowledge that I have the right to revoke this authorization in writing by either: (1) filling out a revocation form available from Florida Heart Clinic, LLC or (2) sending my revocation via letter to Florida Heart Clinic, LLC to the above address. However, I understand that any actions already taken in reliance on this authorization cannot be reversed, and my revocation will not affect those actions. I understand that once health care information is disclosed, the person or organization that receives it may re-disclose it and privacy laws may no longer protect it.

Signature of patient or legally authorized representative

Print name

Authority or relationship to individual, if representative

Date

Time