Atlanta Heart Associates, P.C.

PATIENT AUTHORIZATION FOR PRACTICE TO RELEASE PROTECTED HEALTH INFORMATION TO THIRD PARTIES

By signing this authorization, I authorize Atlanta Heart Associates, P.C. to use and/or disclose certain protected health information (PHI) about me to or for the party or parties listed below.

1) I give my permission for Atlanta Heart Associates, P.C. to leave detailed messages on my answering machine.

Patient Signature__________________________________**Date**___________________

2) I give my permission for Atlanta Heart Associates, P.C. to discuss my medical information with my _______________________ whose name is ____________________________.

Patient Signature__________________________________**Date**___________________

3) I give my permission for Atlanta Heart Associates, P.C. to discuss my financial information with my ________________________ whose name is____________________________.

Patient Signature__________________________________**Date**___________________

When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure 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 Atlanta Heart Associates, P.C. has acted in reliance upon this authorization. My written revocation must be submitted to Atlanta Heart Associates, P.C.'s Privacy Officer at 350 Country Club Drive, Suite A, Stockbridge, Georgia 30281.

Signed by:

__________________________________ __________________________________

Signature of Patient or Legal Guardian Relationship to Patient

__________________________________ __________________________________

Patient's Name Date

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Print Name of Patient or Legal Guardian