CVA Cardiovascular Associates

Medical Record Chart # _____

- ☐ Main Campus: 3980 Colonnade Parkway, Birmingham, AL 35243 (205) 510-5000
- ☐ Brookwood Office: 2010 Brookwood Medical Center Dr., Birmingham, AL 35209, ACC Suite 415 (205) 510-5000
- ☐ Shelby Office: 1004 1st Street North, Suite 270, Alabaster, AL 35007 (205) 621-7935
- ☐ Sylacauga Office: 209 West Spring Street, Suite 104, Sylacauga, AL 35150 (256) 245-5833
- ☐ Talladega Office: 201 Medical Office Park, Talladega, AL 35160 (256) 480-6300
- ☐ Other – CVA Office: _____

HEALTH INFORMATION MANAGEMENT DEPARTMENT

Authorization for Use and Disclosure of Protected Health Information (Medical Records)

I, _____ _____ hereby authorize the use or
(Name of Patient) (Date of Birth)

disclosure of Protected Health Information may be authorized from: _____
(Name & Address of Sending Facility/Individual)

_____

The Protected Health Information may be disclosed to: _____
(Name & Address of Receiving Facility/Individual)

_____

The Protected Health Information is being used for the following purpose(s): _____

The specific information that should be disclosed is:

_____ Office Visit _____ EKG _____ Radiology Report

_____ Cath Report _____ History & Physical _____ Laboratory Report

_____ Consult Report

Other (Specify) _____

_____

_____

In compliance with HIPAA minimum necessary requirement, a "whole" chart request will not be honored. Please send the requested information to the following fax number.

_____Main Campus (205) 599-3570 _____Sylacauga (256) 245-5717 _____Brookwood (205) 599-0308

_____Shelby Office (205) 621-7014 _____Talladega (256) 480-6688

This authorization shall be in force and effective for ninety (90) days, from the date of signature. I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to privacy@cvapc.com. I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law. CVA is not responsible for any information re-disclosed by the third party to whom information is furnished under valid authorization.
[I understand that CVA cannot condition treatment on my willingness to sign authorization (subject to certain exceptions).]

Printed Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____ Date _____

Description of Personal Representative's Authority _____

Witness _____ Date _____