CVA Cardiovascular Associates

Medical Record Chart # ________________

☐ Main Campus: 3980 Colonnade Parkway, Birmingham, AL 35243 (205) 510-5000

☐ 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, ______________________________ (Name of Patient) ____________________ (Date of Birth) hereby authorize the use or 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) 599-9056

_____ Sylacauga (205) 599-9063

_____ Talladega (205) 599-9054

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 ____________