PATIENT AUTHORIZATION

Hall-Garcia Cardiology Associates (HGCA)

THIS NOTICE DESCRIBES HOW INFORMATION ABOUT YOU MAY BE USED AND DISCLOSED AND HOW YOU CAN GET ACCESS TO THIS INORMATION. PLEASE REVIEW IT CAREFULLY.

We may use and disclose protected health information about you only with your authorization. Specific Information may include but is not limited to name of your insurance plan and insurance ID number (including policy and group number);the insured's name, address, phone number, gender, and date of birth, your name, date of birth, address, phone number, gender, and date of birth, dates and types of surgeries, hospitalizations, and treatments; and diagnosis and procedure information.

Name of persons using or disclosing Hall-Garcia Cardiology Associates (HGCA)

Expiration date of authorization: _____

The purpose of the requested use or disclosure is treatment, payment, or health care operations.

By signing this form, you consent to our using and disclosing your protected health information as specified in this authorization. You may revoke this authorization, in writing, except to the extent that we have acted in reliance on your prior consent. To revoke this authorization, you must forward a written revocation referencing this authorization to our Chief Privacy Officer Mary Murphy at:
6624 Fannin, Suite 2480
Houston, Texas 77030

You may refuse to sign this authorization. We will not condition treatment, payment, enrollment in the health plan or eligibility for benefits on your providing this authorization [subject to exceptions]. You may inspect a copy the protected health information in accordance with our Notice of Privacy Practices. We will provide a copy of this signed authorization to you.

Signed by: _____ Date: _____

Print Patient Name: _____

I authorize Hall-Garcia Cardiology Associates to leave necessary messages at my home or place of employment.

Signed by: _____ Date: _____

I authorize Hall-Garcia Cardiology Associates to speak to the following persons regarding my medical condition, lab results, etc.

_____ Relationship to patient: _____

_____ Relationship to patient: _____

Signed by: _____ Date: _____