Ronald J. Bloom, MD, FACC
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Tracy Patel, MD, FACC, RPVI
Maria Theresa Santos, MD, FACC, RPVI

Cottage Grove Cardiology, P.C.
Specializing in Cardiovascular Medicine

Julian Esteban, MD,MS, FACC
Jawad Haider, MD, FACC
Vincent F. Romano, MD, FACC
Erin Vincent, PA-C
Gabriella Smith, PA-C
Jason Cornelio, PA-C

AUTHORIZATION TO REQUEST MEDICAL RECORDS

I hereby authorize the disclosure of my (or dependent) health information concerning:

_____ _____
Print Patient Name Date of Birth

Description of health information to be disclosed (Authorization for the use or disclosure of psychotherapy notes may not be combined with any other type of health information authorization except for other psychotherapy notes):

_____

I understand that this health information may include HIV-related information and/or information relating to the diagnosis or treatment of psychiatric disabilities and/or substance abuse and that by signing this form I am authorizing such information to be disclosed.

This health information may be disclosed by:

_____
NAME AND ADDRESS OF PERSON/ENTITY TO DISCLOSE HEALTH INFORMATION

This information may be disclosed to and used by:

Cottage Grove Cardiology, PC
711 Cottage Grove Road, Bloomfield, CT 06002-3060
Phone: 860-242-8756 Fax: 860-242-3052

The information may be used and disclosed only for the following purposes: **At the request of the individual**

I understand that if I do not sign this form: (Please initial each statement)
_____ My health plan may not enroll me or make me eligible for benefits.
_____ My physician will not perform the expert, employment, life insurance or other physical or medical evaluation which otherwise be performed solely for the purpose of disclosure to a third party.
_____ My physician may not be able to continue treating my condition because these records are necessary for treatment.

Effect of refusal to sign authorization:
I understand that my refusal to sign this authorization will not jeopardize my right to obtain present or future treatment except where disclosure of the information is necessary for the treatment.

Signature:
I understand that I may revoke this authorization at any time by notifying your practice/hospital in writing. My revocation will not affect actions taken by your practice/hospital prior to receipt. I understand that, if the recipient of the information is not a healthcare provided or health plan covered by the federal privacy rule, the information used or disclosed as described above may be re-disclosed by the recipient and no longer be protected by the privacy rule. However, other state or federal law may prohibit the recipient from disclosing specially protected information, such as substance abuse treatment information, HIV/Aids-related information and psychiatric/mental health information.

This authorization is valid for one year from the date below. I understand that I have the right to receive a copy of this authorization.

_____ _____
Signature Date

_____ _____
Print Name Relationship to Patient

REVOCATION SECTION

I hereby revoke this authorization, effective _____/_____/_____.

_____ _____
Patient Signature Date

_____ _____
Printed Name of Patient Birthdate

_____ _____
Signature of Practice Privacy Officer Date

If the practice is seeking this authorization from you for a use or disclosure of you PHI, we will provide you with a copy of this signed authorization.