# PATIENT PRIVACY NOTICE/AUTHORIZATION TO DISCLOSE

Due to the 1996 HIPPA Privacy Act we are not allowed to disclose, copy, transfer, email, fax, mail, etc… any protected health information to anyone without your written consent. Every effort is made to keep your records safe and secure. Upon request, you have the right to have a copy of our written privacy policy at CVD®.

By signing below, you are authorizing us to disclose your medical records to:

1. Primary Care Physician on file
2. Insurance Company on file
3. Family members as listed:

Name _____ Relationship _____

Name _____ Relationship _____

I acknowledge that I have received a copy of our Notice of Privacy Practices related to your treatment at CVD. In the event that you would like your medical records sent on your behalf to a third party, a Medical Records Release is necessary signed by the patient. If you have elected to authorize a family member to receive your records, CVD cannot be held responsible under the HIPPA Privacy Act for re-disclosure of this information to a third party. You have the right to revoke or change this authorization at any time as long as it is done via a written request to the treating physician's office.

_____ Patient or legal Guardian's Signature

_____ Printed Name

_____ Date

_____ Witness