Cardiovascular Specialists of New England

AUTHORIZATION OF RELEASE OF HEALTH INFORMATION PURSUANT TO HIPAA

According to the Health Insurance Portability & Accountability Act of 1996 ("HIPAA"), I understand that my health information is protected and private. I understand that this information will be used for treatment, remittance of payment, and health care operations.

I acknowledge that I have received a copy of Cardiovascular Specialists of New England Authorization of Release of Health Information Pursuant to HIPAA form, outlining my individual rights to my protected health information and the uses of my protected health information.

PATIENT NAME: _____

SIGNATURE: _____

DATE: _____

FOR OFFICE

I have attempted to obtain the patient's signature in acknowledgment of this Authorization of Release of Health Information Pursuant to HIPAA but was unable to do so as documented below:

Name:

Date:

Reason: