Authorization to Disclose Protected Health Information

In order to provide for your healthcare, **Anthony M.D'Agostino, M.D., FACP** collects information about your medical history, physical examinations and test results, diagnoses and treatments. Use and disclosure of protected health information is regulated by a federal law known as The Health Insurance Portability and Accountability Act of 1996 ("HIPAA"). Under HIPAA, healthcare providers must obtain a valid authorization in order to release any such information to a third party for purposes not related to your treatment, receiving payment, or healthcare operations. This gives **Anthony M. D'Agostino, MD, FACP** permission to disclose the elements of your protected health information listed below for the specified purposes to the stated recipient.

I understand that I am nor required to sign this authorization, and that is not conditioned on signing, except as described below. A copy of this authorization will; be provided to me if **Anthony M. D'Agostino, MD, FACP** initiated the request for this authorization.

Exceptions: Anthony M.D'Agostino, M.D.,FACP may condition treatment on signing an authorization for disclosure to a third party if the sole reason for treatment is for disclosure to that party(e.g., a physical being paid for by an insurance company in order to determine eligibility for a policy). Also, provision of treatment that is part of a research study may be conditioned on an authorization to disclose protected health information as required for the conduct of the clinical trial.

Therefore, I, _____DOB :_____(patient or personal representative), consent that **Anthony M. D'Agostino, MD, FACP** may disclose the following health information of (circle one) myself or (specify :) _____.
(If signing as a personal representative, documentation of your legal right to do so must be provided).

Specific Health information to be disclosed, including date(s):
_____.
_____.

Purpose for which the authorization is being requested if the patient or a personal representative is making the request, the purpose can be stated "as at the request of the individual" if he or she does not wish to disclose the purpose. Otherwise, a purpose must be specified.
_____.
_____.
The health information requested is to be disclosed to:
Recipient: _____
Address: _____
_____
City: _____ State: _____ Zip code: _____

This authorization will remain valid until___/___/_____or until the following event related to this authorization takes place: _____, after which time it will become invalid.

I understand that the protected health information released to a third party that is not subject to HIPAA regulations will no longer be protected, and may be subject to redisclosure. Only providers of healthcare(organizations that provide medical or health services or medical supplies), health plans(organizations that pay for medical care), and healthcare claerhouses(organizations that convert health data into the required format for electronic transmittal) are covered by HIPAA I understand that I may revoke this authorization in writing at any time, but that this revocation will not affect any prior authorized disclosures that have been taken by Anthony M .D'Agostino, M.D.,FACP

_____ ____/_____/____ _____
Printed Name Date Signature of patient

_____
Signature of representative