LOWN CARDIOVASCULAR GROUP
830 Boylston Street, Suite 205
Chestnut Hill, MA 02467
TEL: 617 732 1318 FAX: 617 734 5763

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I hereby authorize the **Lown Cardiovascular Group** to use or disclose my individually identifiable health information as described below, only for the purposes and parties also described below:

Patient Name: ____ Date of Birth: __________________________

Address: ____

Description of specific information to be used or disclosed (including dates): _________________________________

____

Persons/organizations authorized to receive the information: ____

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This information is being requested for the following purpose(s):

O Medical Care O Legal O Insurance O Personal O Other

The authorization shall remain in effect from the date signed below until: ________________________________.

I request the release of the specific categories of sensitive information that I have *INITIALED* below:

_____ HIV test results (specify date:____)
_____ Genetic test results (specify type of test: ____)
_____ Alcohol and drug abuse records
_____ Other: (please list ____)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I understand that I may refuse to sign this authorization. If I refuse to sign this authorization, my treatment, payment, health plan enrollment, or eligibility for benefits will not be affected
- I may withdraw my authorization at any time by submitting a written request to the Lown Cardiovascular Center, Attention: Privacy Officer. Authorization may be withdrawn except to the extent that action has been taken in reliance on this authorization.
- Information released on this authorization, if redisclosed by the recipient, is no longer protected by HIPAA.

____ ____________________________
Signature of patient or patient's representative Date

____ ____________________________
Printed name of patient or patient's representative Relationship to patient