PULSE
HEART | VALVE | VASCULAR

# Authorization for Release of Information to Others

Patient Name:_____ Date of Birth:_____

Many of our patients allow other people, such as their spouse, parents, or children, to call and request medical or billing information. Under the requirements of HIPAA we are not allowed to give this information to anyone without the patient's consent. If you wish to have your medical or billing information released to others you must sign this form. Signing this form will give information only to the individuals indicated below.

I authorize Pulse- Heart, Valve, and Vascular Institute to release information to the persons listed below:

1._____ Relation to Patient:_____

2._____ Relation to Patient:_____

3._____ Relation to Patient:_____

**Patient Information**

I understand I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected health information to be disclosed.

I understand that information disclosed to any above recipient is no longer protected by federal or state law and may be subject to redisclosure by the above recipient.

You have the right to revoke this consent in writing.

Signature:_____Date:_____