EPI
ELECTROPHYSIOLOGY AND
PACING INTERVENTIONALISTS

Authorization for Use or Disclosure of Information

I, _____ Date of Birth: _____
hereby authorize _____ to (check those that apply):
___use the following protected health information and/or
___disclose the following protected health information to _____
_____

The following health information and dates of treatment to be used or disclosed, including, but not limited to:_____.
Dates of Treatment:_____.

This protected health information is being used or disclosed for the following purposes:
____continuity of medical care
____research purposes including treatment
____release of information requested by physician and/or other entity

This authorization shall be in force and effect until all records requested are received by the above-mentioned party at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to E.P.I. at 3433 Agler Road. I understand that a revocation is not effective to the extent that EPI has relied on the use or disclosure of the protected health information.

I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.

EPI will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure. I have been made aware of the practice's "Notice of Privacy Practices" and that statements included in this authorization are binding on the EPI.

I understand I have the right to:
- Inspect or copy the protected health information to be used or disclosed as permitted under federal law (or state law to the extent the state law provides greater access rights.)
- Refuse to sign this authorization.

[The use or disclosure requested under this authorization will result in direct or indirect remuneration to E.P.I. from a third party, if applicable.]

_____ _____
Signature of Patient or Personal Representative Date

3433 AGLER ROAD, SUITE 2400 COLUMBUS, OHIO 43219 PHONE:614-428-5553 FAX:614-428-5515
777 WEST STATE STREET, SUITE 306 COLUMBUS, OHIO 43222 PHONE:614-228-0491 FAX:614-228-1089

_____	_____
Name of Patient or Personal Representative	Description of Personal Representative's Authority

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