



MORRISTOWN CARDIOLOGY ASSOCIATES, P.A.

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Diplomates in Cardiovascular Disease
American Board of Internal Medicine
Fellows of the American College of Cardiology*

AUTHORIZATION TO DISCLOSE PARTICIPANT HEALTH INFORMATION

Participant Name: _____

Address: _____

Date of Birth: _____ Date of Request: _____

As required by HIPAA Privacy Regulations, protected health information may not be used or disclosed to a third party without participant authorization.

I hereby authorize Morristown Cardiology Associates, P.A. and its employees to disclose my Protected Health Information to the following person, health care provider, or business associate:

Participant Health Information authorized to be disclosed:

Blood Pressure Monitor - dated _____ Holter Monitor - dated _____
Doppler Study - dated _____ Laboratory Results - dated _____
Echocardiogram - dated _____ Nuclear scan - dated _____
Echo/Stress - dated _____ Sestamibi - dated _____
EKG - dated _____ Stress test - dated _____
Medical Records (be specific) _____

For the specific use or purpose of: (describe in detail):

Effective dates for this authorization: ____/____/____ through ____/____/____. This authorization will expire at the end of the above period.

Signature of Participant or Participant's Authorized Representative

Date

Please review your Rights described on the back of this form

I understand that the information disclosed above may be re-disclosed to additional parties and no longer protected for reasons beyond our control.

I understand I have the right to:

1. Revoke this authorization by sending written notice to this office and that revocation will not affect this office's previous reliance on the uses or disclosure pursuant to this authorization.
2. Knowledge of any remuneration involved due to any marketing activity as allowed by this authorization, and as a result of this authorization.
3. Inspect a copy of Participant Health Information being used or disclosed under federal law.
4. Refuse to sign this authorization.
5. Receive a copy of this authorization.
6. Restrict what is disclosed with this authorization.

I also understand that if I do not sign this document, it will not condition my treatment, payment, enrollment in a health plan, or eligibility for benefits whether or not I provide authorization to use or disclose protected participant health information.