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HURWITZ - ROBERTS, A MEDICAL CORPORATION
Cardiac • Vascular • Thoracic Surgery
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HIPAA Privacy Authorization Form

Authorization for Use or Disclosure of Protected Health Information

(Required by the Health Insurance Portability and Accountability Act, 45 C.F.R. Parts 160 and 164)

1. **Authorization**
I authorize Los Angeles Heart Surgery to use and disclose the protected health information described below.

2. **Effective Period**
This authorization for release of information covers all past, present, and future time periods.

3. **Extent of Authorization**
I authorize the release of my complete health record (including records relating to mental healthcare, communicable diseases, HIV or AIDS, and treatment of alcohol or drug abuse).

4. This medical information may be used by Los Angeles Heart Surgery for medical treatment or consultation, billing or claims payment, or other purposes as I may direct.

5. This authorization shall be in force and effective through the duration of my treatment, at which time this authorization expires.

6. I understand that I have the right to revoke this authorization, in writing, at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition obtaining insurance coverage and the insurer has a legal right to contest a claim.

7. I understand that my treatment, payment, enrollment, or eligibility for benefits will not be conditioned on whether I sign this authorization.

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

_____ _____
Signature of Patient/Personal Representative Date

_____
Printed Name of Patient/Personal Representative