



### Limited Patient Authorization for Disclosure of Protected Health Information

Please print all information, then sign and date form at bottom.

**Name of Practice:** Advanced Cardiovascular Specialists

**Patient Name:** \_\_\_\_\_

**Social Security Number:** \_\_\_\_\_ - \_\_\_\_\_ - \_\_\_\_\_

**Date of Birth:** \_\_\_\_/\_\_\_\_/\_\_\_\_

**Purpose of request (who will be authorized to receive information)** - I authorize the practice to disclose or provide protected health information, about me, to:

Entity/Person receiving information:

Relationship to you:

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**Description of information to be disclosed** - I authorize the practice to disclose the following protected health information about me to the entity, person, or persons identified above:

\_\_\_\_lab results    \_\_\_\_diagnostic test results    \_\_\_\_billing/collections information  
\_\_\_\_any and all information in my health record including but not limited to the above mentioned as well as diagnoses, treatment plans and prognosis

**Purpose of disclosure** (please list the purpose of the disclosure or check patient request):

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Patient Request

**Expirations or termination of authorization:** This authorization will expire one year from the date of your signature below, unless you specify an earlier termination. You must submit a new authorization after the expiration date to continue the authorization. You have the right to terminate this authorization at any time. You must notify our privacy manager, in writing, if you decide to terminate the authorization prior to the normal expiration date.

(Please list an earlier expiration if less than one year): \_\_\_\_\_

**Right to revoke or terminate:** As stated in our Notice of Privacy Practices, you have the right to revoke or terminate this authorization by submitting a written request to our Privacy Manager. This can be done in-person or by mailing a request to the attention of Privacy Manager at:

**Advanced Cardiovascular Specialists**  
**755 N. 11th Street, P2200**  
**Beaumont, TX 77702**

**Re-disclosure:** We have no control over the person(s) you have listed to receive your protected health information. Therefore, your protected health information disclosed under this authorization will no longer be protected by the requirements of the Privacy Rule and will no longer be the responsibility of the practice.

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date

\_\_\_\_\_  
Patient Signature

\_\_\_\_\_  
Date