



Leachman Cardiology Associates, P.A.

AN AFFILIATE OF TEXAS HEART INSTITUTE

- D. Richard Leachman, M.D.
- Roberto Lufschanowski, M.D.
- Paolo Angelini, M.D.
- Zvonimir Krajcer, M.D.
- J. Alberto Lopez, M.D.
- Stephanie Coulter, M.D.
- Eduardo Hernandez, M.D.

6624 Fannin • Suite 2780 • Houston, Texas 77030 • (713) 790-9401 • Fax: (713) 790-0353

AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION PLEASE REVIEW CAREFULLY

To improve the efficiency and effectiveness of the health care system, the Health Insurance Portability and Accountability Act (HIPAA) of 1996, Public Law 104-191 was enacted by the Federal Government and is currently effective. You have reviewed and signed the Notice of Privacy Practices that describes how we disclose your protected health information (PHI) to carry out treatment, payment or health care operations (TPO) and for other purposes that are permitted or required by law.

NOTE: You have the right to request a restriction of your protected health information at any time. However, patients may request we communicate their protected health information to spouses, relatives or friends. Examples are, communicating appointment times, pre-procedure instructions, relaying test results, relaying medication instructions, communicating physician's orders, and other such protected health information to someone besides yourself. If you request this right, we are required to have a completed authorization on file **prior** to releasing your protected health information. If you wish for someone to have access to your protect health information please complete the authorization below.

The protected health information covered by this authorization includes communicating over the telephone the following:
(Please initial by each protected health information you wish to be disclosed)

- | | | |
|---|---|---|
| <input type="checkbox"/> Appointment Times and Instructions | <input type="checkbox"/> Test Results | <input type="checkbox"/> Physician Orders |
| <input type="checkbox"/> Medication Questions | <input type="checkbox"/> Questions Regarding Your Current Health Status | |
| <input type="checkbox"/> Medication Changes | <input type="checkbox"/> Pre-Procedure Instructions | |

I authorize the individuals below access to my protected health information over the telephone:

Name Relation

Name Relation

This authorization is effective until such time as you revoke or terminate this authorization.

You also have the right to request to receive confidential communications from us by alternative means other than speaking with you over the phone. An example is by answering machine or voice mail. These means may not be secure if others have access to them. If you request this right, we are required to have a completed authorization on file **prior** to releasing your information.

The information covered by this authorization includes communicating via the following means:

(Please initial by each method you wish our practice to communicate with you)

- | | | |
|--|--|---|
| <input type="checkbox"/> Answering Machine at Home | <input type="checkbox"/> Voice Mail on CellPhone | <input type="checkbox"/> Voice Mail at Work |
|--|--|---|

This authorization is effective until such time as you revoke or terminate this authorization.

If you would like our office to communicate your protected health information to your primary care physician or referring physician, please indicate their name and address:

Name of Physician: _____

Address of Physician: _____

This authorization is effective until such time as you revoke or terminate this authorization.

Signature below is only acknowledgement that you have read and understand the implications of this authorization to release your protected health information to others designated above, to your referring physician and/or communicate by alternative means.

Print Name: _____ **Signature:** _____ **Date:** _____

REVOCAION OF AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION
PLEASE REVIEW IT CAREFULLY

The Privacy Laws outline your right to revoke or terminate the authorization to use and disclose protected health information at any time.

This notice revokes the authorization to the use and disclose protected health information for:

Name

Relation

Name

Relation

The original consent was signed on:

Date of Original Authorization

Effect of Revocation

Protected health information that is collected on or after the date on which this form is received will not be used or disclosed by our practice for any purposes not related to treatment, payment or health care operations as outlined in the signed Notice of Privacy Practices.

The effective date of the revocation of authorization to use or disclose protected health information is _____.

Signature below is only acknowledgement that you have read and understand the implications of this revocation of authorization to release your protected health information to others as previously designated.

Print Name: _____ Signature: _____ Date: _____