

ISLAND CARDIOVASCULAR ASSOCIATES, LLC

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AUTHORIZATION FOR THE USE AND/OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Patient: _____ Date of Birth: _____ SSN: _____

Type of Release of Authorization

I authorize the above-named physicians to **RELEASE** Protected Health Information to:

(Name)

(Address)

(City, State, Zip)

(Phone No.) _____ (Fax No.) _____ I authorize the above-named

physicians to **OBTAIN** Protected Health Information from:

(Name)

(Address)

(City, State, Zip)

(Phone No.) _____ (Fax No.) _____

Extent of Nature of Information to be Disclosed, including Dates of Treatment or Hospitalization

____ Office Note ____ Labs ____ X-Rays ____ Consultation Reports ____ Other: _____

Purpose or Need for Disclosure

____ Attorney ____ Insurance ____ Medical Care ____ Personal ____ Other: ____

1. I may inspect or receive a copy of the Protected Health Information described by this authorization.
2. I understand that this authorization is applicable to patients with drug or alcohol related diagnoses, in which Title 42, Part 2 of the Code of Federal Regulations and/or the New York State Mental Hygiene Law, governs this request.
3. I understand that my medical records may contain genetic testing information including lab results.
4. I understand that treatment and payment will not be conditional on whether I provide authorization for any requested additional written authorization on my part.
5. I understand that re-disclosure of this information to a party other than the one designated above is forbidden without additional written authorization on my part.
6. I understand that when the information is used or disclosed pursuant to the authorization, it may be subject to re-disclosure by the receiver and may no longer be protected by the federal or state rule.
7. I understand this authorization may be revoked by written notification from the undersigned to this office, except to the extent that action has been taken in reliance upon this authorization.
8. I am aware there may be a fee associated with the production of copies.
9. This authorization will expire within one year unless otherwise specified.

Signature of Witness

(Date)

Signature of Patient/Representative

(Date)