

ISLAND CARDIOVASCULAR ASSOCIATES, LLC

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PRACTICE LIMITED TO CARDIOVASCULAR DISEASES

**AUTHORIZATION TO DISCLOSE MEDICAL INFORMATION AND
ACKNOWLEDGEMENT OF RECEIPT OF HIPAA PRIVACY LAW**

I give authorization to disclose my protected health information to the following:

PLEASE NOTE: If no one is listed, information will be given only to you.

NAME TELEPHONE	RELATIONSHIP	
_____	_____	_____
_____	_____	_____
_____	_____	_____
_____	_____	_____

I understand that I may revoke this authorization at **any** time by giving my written notice to the Privacy Officer at Island Cardiovascular Associates. I understand I do not hold Island Cardiovascular responsible for any actions taken **BEFORE** receipt of my written revocation of this form.

Patient's Signature

Date