



AUTHORIZATION FOR DISCLOSURE OF  
PROTECTED HEALTH INFORMATION (PHI)

I, \_\_\_\_\_ Date of Birth \_\_\_\_\_ give  
Atlantic Cardiology Associates (ACA) my authorization to release / discuss with  
\_\_\_\_\_, the following Medical Information:

- Test Results
- Appointment Information
- Billing / Payment Information
- Other \_\_\_\_\_

I do  
I do not

Give Atlantic Cardiology Associates permission to leave test results and appointment information on my answering machine.

I understand that this authorization may be revoked by me at any time except to the extent that action has been taken in reliance upon it.

The information used or disclosed pursuant to the authorization may be subject to re-Disclosure by the recipient and no longer protected.

This authorization expires one year from the most recent dated signature.

Date \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_ Signature \_\_\_\_\_  
Date \_\_\_\_\_ Signature \_\_\_\_\_