



## Patient Authorization for Use or Disclosure of Protected Health Information

With my consent, Cardiovascular Consultants of Maine, P.A. (CCM) may use and disclose protected health information about me to carry out treatment, payment and healthcare operations. Please refer to CCM's Notice of Privacy Practices for a more complete description of such uses and disclosures.

I have the right to review the Notice of Privacy Practices prior to signing this consent. CCM reserves the right to revise its Notice of Privacy Practices at anytime. A revised Notice of Privacy Practices may be obtained by forwarding a written request to: Privacy Officer, Cardiovascular Consultants of Maine, PA, 96 Campus Drive, Suite 1, Scarborough, ME 04074.

I understand that this authorization shall be in force and effect until I, the patient, request otherwise at which time this authorization to use or disclose this protected health information expires.

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to: **Privacy Officer, Cardiovascular Consultants of Maine, PA, 96 Campus Drive, Suite 1, Scarborough, ME 04074.**

I understand that CCM may mail, call, or email to my home or other designated location any items that assist the practice in carrying out treatment, payment, and/or healthcare operations. (i.e.: appointment reminders, insurance items, information regarding my clinical care, lab results, and patient statements, among others). I understand that CCM has the right to use my medical data in a de-identified manner for research purposes. I understand that information used or disclosed pursuant to this authorization may be disclosed by the recipient and may no longer be protected by federal or state law.

I understand that if I refuse to sign this authorization I may not be eligible for, or receive research-related treatment or treatment that I have requested for the purpose of disclosure to others.

I understand that I have a right to request a restriction on how CCM uses or discloses my Health information. However, the practice is not required to agree to my requested restrictions, but if it does, it is bound by this agreement. I may revoke my consent in writing except to the extent that the practice has already made disclosures in reliance upon my prior consent.

By signing this form, I am consenting to CCM's use and disclosure of my Health information to carry out treatment, payment and healthcare operations.

\_\_\_\_\_  
Signature of Patient or Legal Representative

\_\_\_\_\_  
Print Name

\_\_\_\_\_  
Date

\_\_\_\_\_  
(If signed by Legal Representative, state relationship and authority to do so)

\_\_\_\_\_  
Signature of Witness