



AUTHORIZATION TO DISCLOSE INFORMATION

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I, _____, authorize and permit Upstate Cardiology to disclose the following information: (check all that apply)

- Services rendered at this office (including participation in research studies)
- Office visit, laboratory and/or radiological results
- Information regarding mental illness, substance abuse or infectious diseases
- Medications prescribed
- Scheduled appointments/telephone confirmation of appointments on answering machine
- Billing Statements
- Other

To the following family member or person(s) listed below:

Name: _____ Relationship to Patient: _____

Name: _____ Relationship to Patient: _____

This authorization is effective _____ and shall continue to be effective until otherwise revoked in writing by me. If you wish to revoke this authorization, you must do so in writing to your physician at Upstate Cardiology. If you choose to revoke this authorization, it will become effective upon receipt, but will not apply to disclosures previously made with your consent. My signature below acknowledges that upon request I may receive a copy of Upstate Cardiology's privacy practices.

Yes the office may leave Voice Mail Messages concerning my test results and appointments.

No the office may not leave Voice Mail Messages concerning my test results and appointments.

Patient Name: _____ Date of Birth: _____

Signature: _____ Social Security #: _____

Or Power of Attorney: _____

For Office Use Only

Date Received: _____ **By:** _____ **Acct #:** _____