

**Parkside Cardiology**  
**215 Parkside Drive**  
**Colorado Springs, CO 80910**  
**(719) 471-1775 FAX (719) 632-6055**

**Authorization for Parkside Cardiology Use or Disclosure of Protected Health Information**

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_

SSN: \_\_\_\_\_ Previous Name: \_\_\_\_\_

I request and authorize \_\_\_\_\_ to release  
Health care information of the patient named above to:

Name: \_\_\_\_\_

Address: \_\_\_\_\_

City/State: \_\_\_\_\_ Zip Code: \_\_\_\_\_

For the purpose of: \_\_\_\_\_

This request and authorization applies to:

\_\_\_\_\_ Health care information relating to the following treatment, condition, or dates of treatment:

\_\_\_\_\_ All healthcare information

\_\_\_\_\_ Other: \_\_\_\_\_

I understand that my express consent is required to release any healthcare information related to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, pregnancy, psychiatric disorders/mental health, or drug and/or alcohol use.

I understand that if the person or entity that receives this information is not a healthcare provider or health plan covered by Federal Privacy regulations, the information described above may be re-disclosed and no longer protected by those regulations.

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance on this authorization. This authorization expires **30 days from date of signature.**

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Legal Representative

\_\_\_\_\_  
Relationship to patient

\_\_\_ Copy of power of attorney in chart

\_\_\_ Copy of personal representative paperwork in chart