healthy heart & vascular PLLC
www.healthyheartandvascular.com

Michael Dangovian D.O., F.A.C.C.
Specializing in Cardiovascular Diseases

Authorization For Use and Disclosure of Protected Health Information (PHI)

Name of Patient | Birth Date | ( ) Phone

Address | City | State | Zip

Authorizes:

INDIVIDUAL(S) /AGENCY/ORGANIZATION MAKING DISCLOSURE

Address

City | State, Zip

Disclosure of PHI To:

healthy heart & vascular PLLC / *Michael Dangovian, D.O.*

INDIVIDUAL /AGENCY/ORGANIZATION RECEIVING DISCLOSURE

39242 Dequindre, Ste. 103

Address

Sterling Heights, MI 48310

City | State, Zip

By initiating the spaces below, I specifically authorize the use and/or disclosure of the following health information and/or medical records, if such information and/or records exist:

_____ Please send the entire medical record (ALL information) to the above named recipient.
_____ Medical records needed for continuity of care
_____ Hospital records/reports
_____ Dental records
_____ Laboratory reports
_____ Billing Statements
_____ Other
_____ Office chart/progress notes
_____ Diagnostic imaging reports
_____ Pathology reports

The specific purpose(s) for which use/disclosure is to be made:

I understand that if the person or entity-receiving the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be re-disclosed and no longer protected by these regulations.

I also understand that the person I am authorizing to use and/or disclose the information may receive compensation for doing so.

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

Finally, I understand that I may revoke this authorization in writing at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire 180 days from the date of signing or until (insert applicable date or event).

Signature of Patient or Representative | Date

Print Representative Name (If Applicable) | Relationship to Patient