HIPPA PRIVACY AUTHORIZATION FORM

AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

(Required by the Health Insurance Portability and Accountability Act-45 CFR Parts 160 and 164)

Patient: _____

Date Of Birth: _____ Phone: _____

1). I hereby authorize _____ to use and or disclosure the protected health information described below to:

JORGE BORDENAVE MD

Integrative & Functional Cardiology

8720 North Kendall Dr. Suite 115. Miami Florida, 33176

P) 305-446-2444 F) 305-446-7847

2). I hereby authorize the release of my complete health records. Please send the following medical information:

____ALL Medical Records ___ ALL Hospital Records ____Echo Report

___ Cardiac Cath Report ___ Latest Laboratory Reports ___Nuclear Stress Test

Other _____

3). This medical information may be used by the person I authorize to receive this information for medical treatment or consultation, billing or claims payment or other purposes as I may direct.

4). I understand that I have the right to revoke this authorization, in writing at any time. I understand that a revocation is not effective to the extent that any person or entity has already acted in reliance on my authorization or if my authorization was obtained as a condition of obtaining insurance coverage and that the insurer has a legal right to contest a claim.

5). I understand that my treatment, payment, enrollment or eligibility for benefits will not be conditioned on whether I sign this authorization.

6). I understand this 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.

_____ _____

Signature of Patient or Representive Date