HEARTLAND CARDIOVASCULAR CENTER, L.L.C.℠
Hearts Are the Core of Our Practice℠

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Suite 605
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815-942-5790
815-941-5704

Authorization for Use or Disclosure of Protected Health Information

I , _____ DOB_____authorize my physician and/or administrative and clinical staff of the Heartland Cardiovascular Center, L.L.C. ("Heartland") to (check all that apply):

__disclose the following protected health information to the following parties: _____

__obtain information from _____

Fax:_____Phone_____

Please send records to : Dr._____

____History & Physical;	____ Discharge Summary;	____Operative Reports;
____EKG Tracings;	____ Labs;	____ X-rays;
____Echocardiogram Reports;	____ Cardiac Catheterization Reports;	____ Stress Tests;
____Holter Monitor Reports;	____ Angiographic Films;	

Other_____

This authorization shall be in force and effect until_____ at which time this authorization to use or disclose this protected health information expires. ("End of the research study" and "none" are acceptable for authorization for research purposes only. Otherwise insert a date.)

I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to Heartland's Privacy Contact at 210 N. Hammes Avenue, Joliet, Illinois. I understand that a revocation is not effective to the extent that my physician or Heartland has taken action in reliance on my authorization for the use or disclosure of the protected health information or if my authorization was obtained as a condition of obtaining insurance coverage and the insurer has a legal right to contest a claim.

I understand that information used or disclosed pursuant to this authorization may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that my physician/staff may need to leave messages on my answering machine or with a family member regarding my health care and/or treatment.

My physician will not condition my treatment, payment, enrollment in a health plan or eligibility for benefits (if applicable) on whether I provide authorization for the requested use or disclosure except (1) if my treatment is related to research, or (2) health care services are provided to me solely for the purpose of creating protected health information for disclosure to a third party.

_____ _____
Signature of Patient or Personal Representative Date

_____ _____
Print Name of Patient or Personal Representative Description of Personal Representative's Authority

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For Personal Representatives Only:

If the above is signed by a personal representative, HCC has verified the identity of such representative by:
(a) ____Obtaining a copy of representative's driver license
(b) ____Other_____

Heartland Cardiovascular Center, L.L.C. By:_____