Rodolfo D. Farhy, MD, FACC, FAHA, PLLC

18915 West Twelve Mile Road, Lathrup Village, MI 48076
Phone: (248) 655-4490 Fax: (248) 655-4491

Medical Information - Release Authorization

Patient Name: Date of Birth:

By my signature, I authorize the staff of:

Phone: Fax:

To release my protected personal health information to:

Rodolfo D. Farhy, MD
18915 West Twelve Mile Road
Lathrup Village, MI 48076
Fax: 248-655-4491

Specific information to be used or disclosed:

1. The purpose of this disclosure is for: Continued Cardiac/Medical Care.

2. This authorization **expires in 12 months**, unless an expressed revocation is received.

3. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Privacy Officer of the sender of the information. I understand that a revocation is not effective until received by them and is not effective to the extent that the sender was previously acted in reliance on this authorization.

4. I understand that 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.

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

I acknowledge that I have read and understand this record release authorization.

Signature of Patient (or Personal Representative) Date

Signature of Witness Date