

**Cardiology Associates of Green Bay, Ltd.**  
**AUTHORIZATION FOR DISCLOSURE OF HEALTH INFORMATION**

\_\_\_\_\_  
Name of Patient

\_\_\_\_\_  
Birth Date

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

**I hereby authorize:**

**To disclose my protected health  
Information, as described below, to:**

\_\_\_\_\_  
Name

\_\_\_\_\_  
Name of Individual or Entity

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
Street Address

\_\_\_\_\_  
City, State, Zip Code

\_\_\_\_\_  
City, State, Zip Code

**Information to be released:**

Catheterization reports to include  
cath summary, report and data sheet

Echo-complete

Consultation Report

ETT-complete with tracings

History and Physical Exam

Op Report and Path

Rest and Exercise Studies-complete

Thallium ETT

Chest X-rays

Lab Reports

All Medical Records

**Purpose for Need of Disclosure**

\_\_\_\_\_  
 At the request of the individual

I understand that the health information disclosed as a result of this authorization may no longer be protected by the federal privacy standards and my health information might be redisclosed without my authorization.

**I understand that I have the right to:**

- **Receive a Copy of This Authorization.**
- **Refuse to Sign This Authorization** and that treatment, payment, enrollment in a health plan or eligibility for health care benefits may not be contingent on my signing this authorization.
- **Revoke This Authorization**, except to the extent that the person(s) and or organization(s) listed above have already made in reference to this authorization.

This authorization will remain in effect until the following date(s): \_\_\_\_\_, or event: \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient (or Legal Representative)**

\_\_\_\_\_  
**Date**

\_\_\_\_\_  
**Relationship to Patient**

\_\_\_\_\_  
**Date**