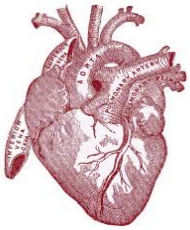

CARDINAL HEART & VASCULAR, PLLC

2609 S HORNER BLVD
SANFORD, NC 27332

4380 FAYETTEVILLE RD
LUMBERTON, NC 28358

PHONE: 919-718-0102
FAX: 919-718-1142
SURIYA JAYAWARDENA MD, FACC, FASCAI

Authorization for Use or Disclosure of Protected Health Information

Patient Name_____ Date of Birth_____

Patient Identification (SSN or chart number) _____

By marking the boxes below, I hereby authorize the use and/or disclosure of the following individually identifiable health information:

Dates of Service_____to_____

Consultation & Office Notes	**Echocardiogram Report**	**Holter Monitor Report**
History & Physical	**Nuclear Stress Test/ETT**	**Electrocardiogram Report**
Event Recorder Report	**Discharge Summary**	**All Medical Records**

Other (must specify) _____

(The above information will be called "Authorized Information" throughout the rest of this form)

Authorized Information requested from:

_____

_____

Release Authorized Information to:

CARDINAL HEART AND VASCULAR, PLLC

PHONE: 919-718-0102/ FAX 919-718-0280

The Authorized Information will be used and/or disclosed for the following purposes:

Personal Use	**Judicial Proceedings**	**Continuation of Medical Care**

Other (must specify) _____

I understand that if the person or entity receiving Authorized Information is not a health plan or health care provider covered by federal privacy regulations, the authorized information may be re-disclosed by the recipient and may no longer be protected by federal or state law.

I understand that I may revoke this authorization at any time by notifying Cardinal Heart & Vascular in writing. However if I choose to do so, I understand that my revocation will not affect any actions taken by Cardinal Heart & Vascular before receiving revocation.

I understand that I may refuse to sign this authorization and that my refusal to sign in no way affects my treatment, payment, enrollment in a health plan, or eligibility of benefits.

Unless otherwise revoked, this authorization will expire on the following date, event, or condition: _____. If fail to specify an expiration date, event, or condition, this authorization will expire in 12 months.

Signature of Patient or Patient Representative_____Date_____

Witness Signature_____

EMAIL US AT: CARDINAL2609@GMAIL.COM