

**Northland Cardiology/Meritas Health Corporation**  
**Authorization for Use and Disclosure of Patient Health Information**

Printed Patient Name: \_\_\_\_\_  
Date of Birth: \_\_\_\_\_ Social Security Number: \_\_\_\_\_

- I authorize (**FROM**): \_\_\_\_\_  
\_\_\_\_\_  
(person or facility, address, city, state and zip code)  
("Provider") to use and/or disclose the following health information from my medical record:

\_\_\_\_\_  
(describe information, including dates and types of conditions)

- I specifically authorize the Provider to disclose the types of information selected below:
  - Information relating to care and treatment for mental health conditions
  - Information relating to care and treatment for drug and alcohol abuse
  - Information relating to HIV testing, infection status, or care and treatment for HIV/AIDS
  - Information relating to genetic testing

- The above information may be disclosed (**TO**): \_\_\_\_\_  
\_\_\_\_\_  
(list person or facility, and address)

- The disclosure is for the purpose of: \_\_\_\_\_.  
If no purpose is stated, the disclosure is made at my request.

- This Authorization expires on the following date or event: \_\_\_\_\_.  
If left blank, this Authorization will expire one (1) year from the date this Authorization is signed.

- I understand that I have the right to revoke this Authorization at any time, except to the extent that the Provider has already taken action in reliance on this Authorization. I may revoke this Authorization by submitting my revocation in writing to the Provider at the address stated above.

- I understand that the information used or disclosed pursuant to this Authorization may be redisclosed by the recipient and may no longer be subject to protection under the Provider's policies and procedures or federal laws protecting the privacy of patients' health information.

- I understand that the Provider does not condition my treatment on my signing this Authorization and that I may refuse to sign this Authorization. However, if the Provider is providing health care solely to create information for disclosure to the third-party named above, the Provider will not provide health care unless I sign this Authorization.

\_\_\_\_\_  
Patient's Signature

\_\_\_\_\_  
Date

If someone other than the Patient signs this Authorization:  
Printed Name: \_\_\_\_\_  
Relationship to Patient:  
\_\_\_\_ Legal Guardian  
\_\_\_\_ Parent  
\_\_\_\_ Other: \_\_\_\_\_ (please specify)