Suffolk Heart Group, LLP

AUTHORIZATION TO DISCLOSE INFORMATION TO FAMILY MEMBERS AND OTHER PERSONS DIRECTLY INVOLVED IN MY HEALTH CARE

I authorize the disclosure of my health information (including HIV/AIDS related information, if any), to the following family members, legal representatives, and close personal friend(s), or other persons who may be involved with my care or payment of healthcare services on my behalf.

1. Representative(s) Name _____

   Phone Number if Different Than Patient _____

   Relationship_____

2. Representative(s) Name_____

   Phone Number if Different Than Patient _____

   Relationship _____

3. Representative(s) Name_____

   Phone Number if Different Than Patient_____

   Relationship_____

   Would you like a copy of your HIPAA rights? Yes_____ No_____

I also authorize the disclosure of my health information (including my HIV/AIDS related information, if any) to any person identified by me in the course of my treatment to the extent such information is directly relevant to this person's involvement with my care or payment of healthcare services on my behalf.

_____ _____

Signature of Patient (or Personal Representative) Date

_____ _____

Printed name of Personal Representative Date