Dysautonomia-MVP Center
2470 Rocky Ridge Road, Ste 200
Birmingham, AL 35243
Phone 205-286-3200 Fax 205-286-3202
staff@mvpctr.com

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

I, _____ _____ hereby authorize the use or
(Name of Patient) (Date of Birth)
disclosure of protected health information about me as described below.

The protected health information may be authorized from: _____
(Name and Address)
_____
_____/_____
(Phone Number) (Fax Number)

The protected health information may be disclosed to: Dr. _____
Dysautonomia-MVP Center
2470 Rocky Ridge Road, Ste 200
Birmingham, AL 35243
Phone 205-286-3200 Fax 205-286-3202

INFORMATION TO BE DISCLOSED:
- ❑ Echocardiogram
- ❑ GXT (Stress Test)
- ❑ Lab
- ❑ Autonomic Function Test (Tilt Table)
- ❑ X-Ray
- ❑ History & Physical
- ❑ Office Notes
- ❑ Other (Specify) _____

PURPOSE OF DISCLOSURE:
- ❑ Personal Record
- ❑ Follow up Health Care
- ❑ Insurance Purposes
- ❑ Other (Specify)_____

Please **FAX** the requested information to **(205) 286-3202**

This authorization shall be in force and effective for one hundred eighty (180) days, from the date of signature. I understand that, as set forth in the provider's Notice of Privacy Practices, I have the right to revoke this authorization, in writing, at any time by sending written notification to Michael Ingram, HIPAA compliance officer.

I understand that a revocation is not effective to the extent that the provider has relied on the use or disclosure of the protected health information. I understand that the information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by federal and state law. The Dysautonomia-MVP Center is not responsible for any information re-disclosed by the third party that information is furnished under valid authorization.

Printed Name of Patient or Personal Representative _____

Signature of Patient or Personal Representative _____ Date _____

Description of Personal Representative's authority _____

Witness _____ Date _____