HIPAA PRIVACY AUTHORIZATION FOR USE AND DISCLOSURE OF PERSONAL HEALTH INFORMATION

This authorization is prepared pursuant to the requirements of the Health Insurance Portability and Accountability Act of 1996 (P.L. 104-192), 42 U.S.C. Section 1320d, et seq., and regulations promulgated thereunder, as amended from time to time (collectively referred to as "HIPAA").

This authorization affects your rights in the privacy of your personal healthcare information. Please read it carefully before signing.

Cardio Terra, Ltd will not condition treatment payment, enrollment in a health plan, or eligibility for benefits, as applicable, on your providing authorization for the requested use of disclosure. YOU MAY REFUSE TO SIGN THIS AUTHORIZATION.

By signing this authorization you acknowledge and agree that Cardio Terra, Ltd may use or disclose your medical information to other healthcare providers involved in your care and for treatment, payment and healthcare operations.

Further, by signing this authorization you acknowledge that you have been provided a copy of and have read and understand Cardio Terra, Ltd's HIPAA Privacy Notice containing a complete description of your rights, and the permitted uses and disclosures, under HIPAA. While Cardio Terra, Ltd has reserved the right to change the terms of its Privacy Notice, copies of the Privacy Notice as amended are available from Cardio Terra, Ltd by sending a written request with return address to Privacy Manager 4112 Monroe Rd Celina, OH 45822-9250.

In accordance with your rights under, and subject to certain restrictions imposed by HIPAA, you may inspect or copy your PHI in the designated record set maintained by Cardio Terra, Ltd for as long as the PHI is maintained in the designated record set.

You have the right to revoke this authorization, in writing, at any time, except to the extent that Cardio Terra, Ltd has taken action in reliance on it. A revocation is effective upon receipt by Cardio Terra, Ltd of a written request to revoke and a copy of the executed authorization form to be revoked at the address listed above.

This authorization shall expire upon the earlier occurrence of: a) revocation of the authorization, b) a finding by the Secretary of the US Department of Health and Human Services, Office of Civil Rights that this authorization is not in compliance with requirements of HIPAA, c) complete satisfaction of the purposes for which this authorization was originally obtained, to be determined in the reasonable discretion of Cardio Terra, Ltd, or d) six years from the date this authorization was executed.

By signing this authorization you acknowledge and agree that any information used or disclosed pursuant to this authorization could be at risk for re-disclosure by the recipient and no longer protected under HIPAA.

Cardio Terra, Ltd will provide the patient, upon request, with a copy of this authorization.

Acknowledged and agreed to by: PATIENT NAME:_____

_____ _____

Patient Signature or Authorized Representative Date

May we leave messages at home with other residents	yes ◉	no ○
May we leave personal health information on your answering machine/voicemail	yes* ◉	no ○
May we contact you via e-mail or cellular telephone	yes** ◉	no ○
May we contact you via text message	yes** ◉	no ○

*Appointment reminders will be left on voicemail.

**We cannot ensure the confidentiality of information shared by these means.

Please list the names of all individuals with whom we may talk to about your medical concerns: Please note, that we will not release any personal health information to anyone unless they are listed.

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____

Name_____Relationship_____Phone#_____