MORRISTOWN CARDIOLOGY ASSOCIATES
435 SOUTH STREET, SUITE 100
MORRISTOWN, NEW JERSEY 07960-5350

Arthur P. Fisch, M.D.*
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Richard I. Watson, M.D.*
Audrey F. von Poelnitz, M.D.*
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Allen Hsieh, M.D.*
Jeffrey G. Schwartz, M.D.*
Craig M. Rosen, M.D.*

Diplomates in Cardiovascular Disease
American Board of Internal Medicine
*Fellows of the American College of Cardiology**

HIPAA

Patient Authorization to Use or Disclose Protected Health Information

By signing this document, I authorize Morristown Cardiology Associates, P.A. to use and/or disclose protected health information (PHI) about me to:

____

____

____

Name(s) of entity/entities or family member to receive information

It is okay to leave a message on my answering machine at the following telephone number(s):

____

This authorization permits Morristown. Cardiology Associates, P.A. to use and/or disclose the following PHI about me: (Please be specific, i.e.: dates of service, type of service, ALL)

____

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The information is used or disclosed at the request of the individual.

This authorization will expire one year from today.

I do not have to sign this authorization in order to receive treatment from Morristown Cardiology Associates, P.A.. I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to redisclosure by the recipient and may no longer be protected by the Federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing to the extent that Morristown Cardiology Associates, P.A. has acted in reliance upon this authorization. My written revocation must be submitted in writing to the above address.

____________________ ____________________
Signed by: Relationship to Patient

____________________ ____________________
Patient's Name: Date:

**** The Patient/Legal Guardian may request a photocopy of this signed authorization ****

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MEDICATION LIST

Patient Name: ___________________________ Date: ________________________

Medication	Dose	Frequency