The La Jolla Cardiovascular Research Institute®

Robert J. Russo, MD, PhD
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AUTHORIZATION FOR USE OR DISCLOSURE OF PROTECTED HEALTH INFORMATION

Completion of this form authorizes the disclosure and/or release of Protected Health Information in accordance with the Privacy Rule of the Health Insurance Portability and Accountability Act of 1996 (HIPAA),and pursuant to 45 CFR 164.508. Failure to provide all information requested may invalidate this authorization.

Patient Name: ______________________________ Date of Birth: ____________________

Phone: ____________________________________ Last 4 of SSN: ____________________

☐ I hereby authorize **Robert J. Russo MD, PhD/ La Jolla Cardiovascular Research Institute** to obtain my medical information from:

Institution: Scripps Clinic Health Information/Green Hospital Health Information

Address: 10666 N. Torrey Pines Road La Jolla, CA 92037

Phone: 858-554-8551 **Fax:** 760-635-0566

Purpose for this request: Ongoing Cardiovascular Care

Medical Records are requested by: ☐ mail ☐ fax ☐ electronic format

Medical Records to include (and limited to) the following **within the last 4 years**:

- ☐ **Progress note** (Cardiology/Cardiovascular Diseases)
- ☐ **Consultation** (Cardiology/Cardiovascular Diseases)
- ☐ **Hospital Discharge Summary**
- ☐ **Echocardiogram** report (Transthoracic or Transesophageal)
- ☐ **Stress Test (treadmill; Dobutamine/treadmill echo; adenosine/treadmill stress Cardiolite)**
- ☐ **Resting ECG**
- ☐ **Chemistry panel** (Complete or Basic Metabolic Panel) or **Lipid Evaluation**
- ☐ **Cardiac Catheterization Report** (coronary angiogram including stent placement)
- ☐ **Holter monitor (or other arrhythmia monitor) report**
- ☐ **Operative note (cardiac surgery; pacemaker generator implantation)**
- ☐ **Cardiac MRI or CT scan**
- ☐ **Overnight oximetry (ambulatory or hospitalized sleep study)**
- ☐ **Radiology reports** (including chest X-ray)
- ☐ **Other:** ____

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________ **Initial** I understand that the information in my medical record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse. I understand that by signing this authorization, I am authorizing the release of such information unless otherwise specified.

________ **Initial** Patient is aware of confidentiality risks involved and releases LA Jolla Cardiovascular Research Institute from any liability that may arise, provided the HIPAA compliance standards intended to maintain the confidentiality and integrity of my Protected Health Information are upheld.

My Rights

- I may inspect or obtain a copy of the PHI that I am being asked to allow the use or disclosure of
- I may revoke this authorization at any time, but I must do so in writing and submit it to the LA Jolla Cardiovascular Research Institute practice entity
- Information disclosed pursuant to this authorization could be re-disclosed by the recipient
- I may refuse to sign this authorization; however, this refusal will not preclude my eligibility for services and benefits
- This authorization remains valid for two years
- I have a right to receive a copy of this authorization

______________________________ ______________
Signature Date

If signed by someone other than the patient, indicate your relationship to the patient:

______________________________ ______________
Signature/ Relationship Date