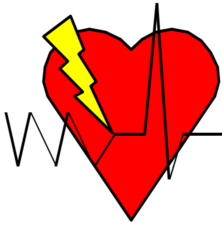

Arrhythmia Center of Northern California

Walter Kusumoto M.D. M.P.H.

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PATIENT DISCLOSURE AUTHORIZATION FORM

Patient Name:________________________________ Date of Birth:__________ Todays Date:______________

I authorize disclosure of my protected health information only in the specific manner and to the specific individual described below:

Choose ONE person to whom this practice may disclose my protected health information:

Name:_______________________________________ Relationship:__________________________________

Voice mail messages with my protected health information may be left on the following one or two phone number(s).

1.____ 2.____

This authorization provides that:

- I may revoke this authorization at any time, provided that the revocation is in writing to the Privacy Officer, Arrhythmia Center of Northern California, 1645 Esplanade, Suite 3, Chico, CA 95926.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected by HIPAA privacy rules.
- This practice will not condition treatment on my providing authorization for the requested use or disclosure.
- I have the right to access my protected health information to be used or disclosed.

Signature_______________________________________ Date______________________________________

Relationship to patient (if signed by a personal representative of patient): _________________________________