heartrhythm solutions

Awais K. Humayun, MD, FACC, FHRS

Authorization for Disclosure of Protected Health Information

This *Authorization for Disclosure of Protected Health Information* (PHI) form should be signed after you receive a copy of Heart Rhythm Solutions' *Notice of Privacy Practices*. **Your signature authorizes Heart Rhythm Solutions (HRS), the office of Awais K. Humayun, to receive, use, and disclose protected health information (PHI) about you as described in the aforementioned notice.**

I understand that services provided by Heart Rhythm Solutions (HRS) are reliant upon receipt of PHI to provide treatment, claim payments, bill services, manage health care operations, contact me, and if specified, communicate with my family, or others identified in this authorization. I understand that there are other, less common, potential uses and disclosures of PHI, which have been explained in *Part II of HRS' Notice of Privacy Practices*. I understand my rights to revocation of this authorization, as well as my rights with respect to PHI as they were explained in *Part III of HRS' Notice of Privacy Practices*. **My signature below confirms my receipt of HRS' *Notice of Privacy Practices* and my consent to the terms and conditions set forth in it.**

I authorize covered entities checked below to disclose PHI to Heart Rhythm Solutions (HRS), the office of Awais K. Humayun, and to receive PHI from HRS, the office of Awais K. Humayun (e.g., cardiac catheterizations, EKGs, pacemaker/monitoring/device reports / data, ECHO reports, stress tests, clinical/office notes, and any other healthcare data required for evaluation, treatment, or health insurance purposes). ***Required***

- ❑ Primary Care Physician* Name: _____ Phone: _____
- ❑ Cardiologist* Name: _____ Phone: _____
- ❑ Other Specialist Name: _____ Phone: _____
- ❑ Other Medical Name: _____ Phone: _____

Hospitals*

- ❑ Memorial Regional Hospital
- ❑ Memorial Hospital Miramar
- ❑ Memorial Hospital Pembroke
- ❑ Memorial Regional Hospital South
- ❑ Memorial Hospital West
- ❑ Florida Medical Center
- ❑ Jackson North Medical Center
- ❑ North Shore Medical Center
- ❑ Aventura Hospital & Medical Center
- ❑ Westside Regional Medical Center
- ❑ HCA Florida University Hospital
- ❑ Other: _____

_____ _____
Patient Name (Print) **DOB: (MM/DD/YY)**

_____ _____
Patient Signature **Date (Authorization valid for 1 year)**

_____ _____
PRINT (Legal Representative for Patient) Relationship to Patient

_____ _____
Signature (Legal Representative for Patient) Date (Authorization valid for 1 year)

4801 S University Drive, Suite 104 | Davie, Florida 33328 | P: (954) 707-5200 | F: (954) 526-4562 | heartrhythmsolutions.com

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DISCLOSE: I authorize the following **individuals, categories, or entities** checked below **to disclose protected health information (PHI) to Heart Rhythm Solutions (HRS), the office of Awais K. Humayun**, on the terms and conditions set forth in this authorization. If any box is checked, please identify persons, or class of persons authorized to disclose PHI to HRS.

- ❑ Family Members without Conservatorship (please specify): _____
- ❑ Residential and/or Community Programs (please specify): _____
- ❑ Psychological Services, Inpatient Psychiatric Hospitals (please specify): _____
- ❑ HIV /other protected test results (please specify): _____
- ❑ Attorneys (please specify): _____
- ❑ Law Enforcement (please specify): _____
- ❑ Military (please specify): _____
- ❑ Other: _____

RECEIVE: I authorize the following individuals, categories, or entities checked below **to receive PHI about myself, and if necessary, my family from HRS, the office of Awais K. Humayun** on the terms and conditions set forth in this authorization.

- ❑ Family Members without Conservatorship (please specify): _____
- ❑ Residential and/or Community Programs (please specify): _____
- ❑ Other Medical/Therapeutic Services (please specify): _____
- ❑ Attorneys (please specify): _____
- ❑ Other: _____

Patient Name (Print)	**DOB: (MM/DD/YY)**
Patient Signature	**Date (Authorization valid for 1 year)**
PRINT (Legal Representative for Patient)	Relationship to Patient
Signature (Legal Representative for Patient)	Date (Authorization valid for 1 year)

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Preferred Primary Communication Methods

- ❑ Home phone: _____
- ❑ Mobile phone: _____
- ❑ Work phone: _____
- ❑ Other phone: _____
- ❑ Personal email: _____
- ❑ Work email: _____
- ❑ Other email: _____
- ❑ Different Billing Address: _____
  _____
  _____

Other preferred communication method (if primary method fails):

- ❑ Home phone: _____
- ❑ Mobile phone: _____
- ❑ Work phone: _____
- ❑ Other phone: _____
- ❑ Personal email: _____
- ❑ Work email: _____
- ❑ Other email: _____
- ❑ Other Method: _____

Other Communication Requests: _____

Patient Contacts: Florida law generally requires patient consent for entities to contact patients for purposes of providing information regarding treatment alternatives, services, or goods. If you request information that you have specified may be of interest to you regarding Heart Rhythm Solutions (HRS), Dr. Humayun, office activities, or services offered, explicit consent is required to contact you. Consent here for these communications, or as the need arises later.

- ❑ I consent to HRS contacting me for purposes of providing *information regarding treatment alternatives, services, activities, or goods, for which I have specified are of interest to me.*
- ❑ I do not consent.

Patient Communication Preferences: HRS will use the primary method(s) of contact you specify below. If none are specified, HRS staff will contact you at your home or mobile telephone number, and you will receive billing documents at your home address. This authorization expires 1-year after the signature date.

Patient Name (Print)	**DOB: (MM/DD/YY)**
Patient Signature	**Date (Authorization valid for 1 year)**
PRINT (Legal Representative for Patient)	Relationship to Patient
Signature (Legal Representative for Patient)	Date (Authorization valid for 1 year)

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RECORDS RELEASE FORM

(FAX REQUEST TO MEDICAL PROVIDERS, FACILITIES, HOSPITALS, ETC.)

To: _____

_____

_____

_____

_____

Patient: _____

_____

_____

_____

DOB: _____

Please be so kind as to send the following medical records for the above patient. This request and authorization applies to:

❑ **Healthcare Records:** _____

_____

_____

❑ **Other:** _____

_____

_____

Thank you for your help. Please fax this page back with the patient's medical records.

Upon signing, I agree to share any records pertaining to my medical care with Heart Rhythm Solutions | Dr. Awais K. Humayun, MD. This authorization expires 1-year after the signature date.

_____ _____

Patient Name (Print) **DOB: (MM/DD/YY)**

_____ _____

Patient Signature **Date (Authorization valid for 1 year)**

_____ _____

PRINT (Legal Representative for Patient) Relationship to Patient

_____ _____

Signature (Legal Representative for Patient) Date (Authorization valid for 1 year)

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