AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION OF
(Student's Name) _____

A. *Authorized Recipients*. I, (Student's Name)_____, authorize HEARTOLOGY PATIENT ADVOCACY and AGENTS THEREOF to request, receive and review any information, verbal or written, regarding my physical or mental health, including medical and hospital records, execute any releases or other documents required to obtain such information, and disclose such information to such persons or entities as he or she may deem appropriate.

B. *Grant of Authority*. Regardless of my capacity or ability to make my own health care decisions, I authorize and request any physician, health care professional, health care provider, and medical care facility to provide to such person(s), information relating to my physical and mental condition and the diagnosis, prognosis, care, and treatment thereof upon his or her request. In addition to my inherent legal right to grant this authority, it is my intent by this authorization for such person(s) to be considered a personal representative under privacy regulations related to protected health information and for such person(s) to be entitled to all health information in the same manner as if I personally were making the request. This authorization and request shall also be considered a consent to the release of such information under current laws, rules, and regulations as well as under future laws, rules, and regulations and amendments to such laws, rules, and regulations to include but not be limited to the express grant of authority to personal representatives as provided by Regulation Section 164.502(g) of Title 45 of the Code of Federal Regulations and the medical information privacy law and regulations generally referred to as HIPAA.

C. *Termination*. The authority granted in this paragraph shall commence immediately and shall not terminate until the earlier of termination of my contract with Heartology Patient Advocacy, my death, or my express revocation of this authority being provided in writing to whomever may be relying upon the authority granted by this paragraph.

D. *Re-disclosure of Information*. I understand when information is used or disclosed pursuant to this authorization it may be subject to re-disclosure and may no longer be protected by privacy rules.

I, (Student's Name)_____, have signed this Authorization for Release of Protected Health Care Information on _____, 20_____, which shall be the effective date of this Authorization.

(Student's Signature)_____