AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

(One form per entity)

Patient's Name: _____ Birth Date: _____

INFORMATION TO BE RELEASED

INSTITUTION / PHYSICIAN:
Address: City State Zip
Phone: Fax:

TYPE OF MEDICAL INFORMATION REQUESTED:

__Cardiac/Vascular Records
__Laboratory Results
__EKG
__Discharge, Consult, H&P
__Other
__Diagnostic Imaging
__Echocardiograms/Nuclear Stress Test
__All Cardiac and Vascular Testing
__OP Notes/Cath Reports

REASON FOR REQUEST: __ Personal, __Transfer of Care, __Disability, __Insurance, __Legal Review, __Continuing Care
__Other (please explain):

I understand that the information in my health 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 or self-paid services. You are hereby *specifically authorized to release* all information or medical records relating to such diagnosis, testing, or treatment, unless specifically excluded below.

I understand that if the organization authorized to receive the information is not a health plan or healthcare provider or other entity considered a covered entity under HIPAA, the released information may no longer be protected by federal privacy regulations. I further understand that information disclosed pursuant to this authorization may be re-disclosed by the parties listed below and no longer protected.

I hereby consent to the release of the specified information relating to diagnosis, testing or treatment to the person or entity named above. I understand that such information cannot be released without my informed consent. I acknowledge I have fully reviewed and understand the contents of this authorization form. My signature below indicates that I hereby agree to and authorize the release of patient health information to the above named person or organization. I have the right to revoke or cancel this authorization, in writing, at any time. I understand that I do not have to sign this authorization in order to get health care benefits (treatment, payment, enrollment, or eligibility for benefits**).** *Federal laws prohibit the recipient from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains or as otherwise permitted by 42 CFR Part 2.*

There may be a charge for copies of your medical records unless your copies are being sent to another physician or healthcare facility.

If the Practice is seeking this authorization from you for a use or disclosure of your PHI, we will provide you with a copy of this signed authorization

AUTHORIZATION SECTION:

This authorization expires _____ (date or event). Authorization expires in 12 months if not otherwise specified

Patient Signature _____Date _____

Parent or Legal Guardian _____Date _____

Relationship to patient, if other than patient _____
(Must provide legal documentation as proof for power of attorney or guardianship)

REVOCATION SECTION:

I hereby revoke this authorization, effective _____/_____/_____.

_____ _____
Patient Signature Date

_____ _____
Printed Name of Patient

_____ _____
Signature of Practice Privacy Officer Date

TCAVI Medical Records
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