

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT NAME: _____

MAIDEN OR OTHER NAME(S): _____

PATIENT'S BIRTHDATE: _____

WHO HAS THE INFORMATION YOU WOULD LIKE RELEASED?

FACILITY/ DR'S NAME: _____

ADDRESS: _____

TO WHOM SHOULD THE INFORMATION BE SENT?

FACILITY/DR'S NAME: _____

MAILING ADDRESS: _____

INFORMATION TO BE DISCLOSED DATES: FROM _____ TO _____
____ OFFICE VISIT
____ ECHOCARDIOGRAM
____ EKG
____ HOSPITAL REPORTS
____ OTHER: _____

REASON FOR RELEASE
____ INSURANCE COVERAGE _____ MOVED _____ DR APPT
____ PERSONAL _____ NEW CARDIOLOGIST
____ PRIMARY CARE DR _____ LEGAL

I UNDERSTAND THAT I MAY REVOKE THIS CONSENT AT ANY TIME. THIS CONSENT WILL AUTOMATICALLY EXPIRE ONE YEAR FROM DATE OF SIGNATURE.

PATIENT'S SIGNATURE: _____ DATE: _____

PARENT'S SIGNATURE
FOR MINOR CHILD: _____ DATE: _____

WE ARE HEREBY AUTHORIZED TO RELEASE ANY RECORDS OR OTHER PROFESSIONAL INFORMATION, IN ACCORDANCE WITH OUR POLICY, TO THE ABOVE NAMED, BY RECEIPT OF THIS AUTHORIZATION, WE ARE RELEASED FROM ALL LEGAL LIABILITIES THAT MAY ARISE FROM RELEASE OF THE INFORMATION REQUESTED.