



AUTHORIZATION FOR RELEASE OF INFORMATION

Name: _____
Last First MI Maiden or other name

Date of Birth ____ - ____ - ____ SS# ____ - ____ - ____ Acct # _____
Month Date Year

Address _____

City _____ State _____ Zip _____ Phone Number _____

I hereby authorize Cardiology Associates, P.C.
(check one)

to obtain my Protected Health Information from:

to release my Protected Health Information to:

Name: _____

Address: _____

City, State, Zip: _____

Phone: _____

Fax: _____

Information to be released / Date of Service
(check all that apply)

Entire Medical Record _____

History & Physical Exam _____

Lab reports _____

Progress Notes _____

Other _____

X _____
 Signature of Patient or Authorized Person Date

If you are requesting CAPC to obtain records, please select whether or not you agree with the following statements:

- I **DO / DO NOT** (circle one) want the obtained records to become part of my official medical record with CAPC.
- CAPC **DOES / DOES NOT** (circle one) have authority to re-release information from outside sources.

Purpose of Disclosure

- Changing Physicians Personal Use School Consultation/Second Opinion
- Continuing Care Insurance Legal Workers Compensation/PIP
- Other _____

Patient Notification Elements

- I understand that this authorization will expire 365 days from the date I have signed this form.
- I understand that I may revoke this authorization at any time by notifying Cardiology Associates, P.C. in writing and it will be effective n the date notified, except to the extent action has already been taken in reliance upon it.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations.
- I understand that:
 - My health care and payment for my health care will not be affected if I do not sign this form.
 - I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
- I understand that I will pay a fee, per Cardiology Associates, P.C. Access of Health Information Fee Schedule (available upon request) for copying and inspection of records.

X _____
Authorization Signature **Date**

Patient Other (Specify) * _____
 * must be accompanied by legal documentation verifying authorization. CAPC Staff Initials: verify authorized signature.

FOR OFFICE USE ONLY

Authorization Exp: _____

Records received by: _____

Relationship to patient: _____

Type of photo ID presented: _____

Fee Collected: \$ _____

Your request to access your medical records has been denied or the release of your record in its entirety cannot be granted. Please see the attached letter for further information.

This is to notify you that your original records request cannot be compiled within twenty-one (21) days of your original request. Your records will be released or available for inspection by _____ (not to exceed 30 additional days)

X _____
 CAPC Staff Signature Date