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Authorization Form for Release of Confidential Health Information

I, _____ hereby authorize _____
(Name of patient or authorized agent) (Name of physician, physician's group, or hospital)

the right to release health records to: _____
(Name of Health Care Facility, Physician, Agency, etc.)

_____
(Street Address, City, State, and Zip Code)

The following information contained in the patient records of: _____
(Patient's Name)

_____
(Date of Birth)

_____
(Social Security Number)

residing at: _____
(Street Address, City, State, and Zip Code)

- o The entire medical record, excluding mental health treatment, alcoholism treatment, drug abuse treatment, and HIV / acquired immune deficiency syndrome (AIDS) records.
- o Stress Test
- o Cardiac Catheterization Report
- o Cardiac Catheterization Films
- o Angioplasty Report
- o EKG
- o Echo Report
- o Holter and / or Event (TTAM) Report
- o Surgical Report
- o Laboratory Report
- o X-Ray Reports
- o Tests done in the last month
- o Tests done in the last year
- o Other: _____

The above information for the following period of time shall be released:
From: _____to _____.
Date Date

The purpose(s) of the authorization is (are) _____I understand that I have the right to inspect and copy the information I have authorized to be disclosed by this authorization. In the event I refuse to authorize the release of the above described information, I understand that it will not be disclosed, except as provided by law. understand that the practice may not condition treatment on whether I sign authorization, except when the provision of health care is solely for the purpose of creating protected health information for disclosure to a third party. understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.

Signed: _____ Date: _____
(If you are not the patient, please specify your relationship to the patient)