Authorization to Release Confidential Medical Information

I, _____ DOB _____/_____/_____ SSN# _____-_____-_____

Address _____

City _____ State _____ Zip Code _____ Phone (_____) _____

Authorize:

( ) *Cardiology Associates of Fredericksburg, 9530 Cosner Drive, Fredericksburg, Virginia 22408, (540) 373-1331*

and/or:

( ) *Other Physician's Office:* _____

to release the information specified below, in accordance with the Commonwealth of Virginia policies to the party identified below.

Release of Information to Person/Organization as noted below:

Name: Dr. Anita Banerjee

Organization: Premier Cardiac and Vascular

Address: 5411-D Backlick Road, Suite 100

City: Springfield State: VA Zip Code: 22401

Phone (703) 563 - 1575 Fax (877) 278 - 1104

Information to be Released/Obtained

(✔) Chart as Specified (MOST RECENT EKG scan ONLY, MOST RECENT lab results, MOST RECENT Echo, MOST RECENT clinical notes, EKG/Stress Test/procedure *REPORTS - NO SCANS*, and ALL cath lab REPORTS)

( ) Other (please specify) _____

Dates of Service _____ to _____

The purpose for the disclosure of the above information is:

_____ Continuing Care

_____ Personal Use

_____ Other _____

I hereby authorize, allow, and cause the release of information indicated above. No threat or other coercive measures have induced me to sign this form. I may request to inspect or copy any information used/disclosed under this authorization.

_____

Patient Signature *Date*

_____

Parent/Guardian/Patient Designee Signature *Date*

_____

Authority of Individual Signing for Patient *Date*

Authorization to Release Confidential Medical Information

Authority of Individual Signing for Patient *Date*