

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: 609 Jefferson Davis Hwy, Suite 201

City: Fredericksburg 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