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Authorization for the Release of Protected Health Information

Patient Name:	
Date of Birth:	Phone:
I authorize representatives from 0	Cardiology Associates to release or obtain the health information directed below:
	Self (Patient) Obtain from/ Release to:
Facility:	
Address:	
Phone Numbe	er:
Fax Number:	
	Release to/ Obtain from:
	Cardiology Associates of Frederick 74 Thomas Johnson Drive Frederick, MD 21702
Phor	ne (301) 694-9033 Fax (301) 694-6204
his request applies to:	
All healthcare information.Healthcare information rela	ating to the following treatment, condition, or dates:
• Other:	
ignature:	Date: