CARDIAC CARE CONSULTANTS
AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date:

Patient Name: **Date of Birth:**

Address:
Telephone Number:

1) I authorize Cardiac Care Consultants to release information contained in my medical record to:

_____
PHYSICIAN NAME

_____
ADDRESS CITY, STATE ZIP CODE

_____
PHONE NUMBER FAX NUMBER

2) I understand that medical information may include if applicable: Alcohol and/or drug abuse and/or mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II. Information about Human Immunodeficiency Virus - HIV, acquired immunodeficiency syndrome - AIDS, and AIDS related complex - ARC, as defined by Department of Public Health rules(1989 Public Act 174) Third Party Information

3) Specific information to be disclosed: (please include dates of treatment)

History and Physical_____ Stress Test_____
Discharge Summary_____ Echocardiogram_____
Clinic Records_____ Lab reports_____
X-rays_____ EKG_____
Holter/Event Monitor_____

All current records within last year _____ Other_____

4) I understand that I may revoke this authorization at anytime and that it will remain in effect for a period of 12 months from the date signed. This authorization pertains to fulfillment of the above stated purpose(s).

I have read the above, and acknowledge that I am familiar with and fully understand the terms and condition of this authorization.

_____ _____
Patient, Parent or Guardian Signature Date

Copies needed by:_____ Records copied by:_____