PRESBYTERIAN HEART & VASCULAR group

Medical Release of Information Form

Patient Name: _____ Date of Birth: _____

Social Security #: _____ Previous Name: _____

I authorize Dr. _____
To release copies of my results **to**:

_____
Name of Physician or Institution

_____
Address

_____
City, State, Zip

I authorize Dr. _____ to obtain copies of my records **from**:

_____
Name of Physician or Institution

_____
Address

_____
City, State, Zip

Reason for release:
_____

This request and authorization applies to: (initial appropriate line)

_____ Health Care information relating to the following treatment condition or dates of treatment.

_____
This information may contain x-ray reports, lab reports, EKG reports, other diagnostic reports, consults.

_____ All Health Care information including information relating to HIV/AIDS testing, sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply.)

_____ All Health Care information excluding information relating to HIV/AIDS testing sexually transmitted diseases, psychiatric disorders / mental health or drug and/or alcohol use. (Please circle all that apply.)

_____ I understand I have the right to revoke this authorization by providing a written request to do so to the above named physician or organization. I understand that the revocation will not apply to information that has already been released.

_____
Signature of patient or authorized representative Date

_____
Relationship or status if signed by anyone other than the patient (parent, legal guardian, personal representative, etc.)

Unless otherwise revoked, this Authorization will expire six months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by confidentiality rules.

Home Phone: _____

Work / Cell phone: _____