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CARDIOLOGY ASSOCIATES

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AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

DATE OF BIRTH: _____ / _____ / _____

TO / FROM

DOCTOR / FACILITY: _____

PHONE NUMBER: (_____) _____ - _____

FAX NUMBER: (_____) _____ - _____

This authorization may include disclosure of information relating to DRUG, ALCOHOL and SUBSTANCE ABUSE, MENTAL HEALTH INFORMATION, CONFIDENTIAL HIV/AIDS-RELATED INFORMATION, and GENETIC INFORMATION. In the event the health information described above includes any of these types of information, I authorize release of such information to the person or entity indicated herein.

INFORMATION TO BE RELEASED (click boxes below)

- ☐ Physicals
- ☐ Consultations
- ☐ Treadmills
- ☐ Lab Results
- ☐ Echocardiograms
- ☐ Progress Notes
- ☐ Discharge Summaries
- ☐ EKGs / ECGs
- ☐ Chest X-Rays
- ☐ Nuclear Stress Reports
- ☐ Operative Reports
- ☐ Cardiac Cath Reports
- ☐ Holter / Event Monitors
- ☐ Other Radiology Reports
- ☐ Vascular Reports

OTHER (Please Specify): _____

_____

I have read this form and agree to the uses and disclosure of the information as described.

_____ _____
Patient Name/Legal Representative Date

_____
Signature