



Heart & Vascular Specialists Patient Registration & Consent Packet

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Authorization to Release Confidential Health Records

This form is for a disclosure of records that requires the patient's authorization. Complete all applicable fields.

PATIENT / INDIVIDUAL

Individual's Name: _____ DOB: ____/____/____

Address: _____

Phone: _____ Email: _____

HEALTH CARE ENTITY AUTHORIZED TO DISCLOSE

Health Care Entity's Name: _____

Address / Location (if needed): _____

RECIPIENT

Person, Agency, or Health Care Entity to Whom Disclosure Is to Be Made:

Name: _____

Address: _____

Phone: _____ Fax/Secure Email: _____

INFORMATION OR HEALTH RECORDS TO BE DISCLOSED

☐ Office Visit Notes ☐ Cardiology Consultation ☐ Stress Test ☐ Nuclear Stress Test

☐ EKG/ECG ☐ Echocardiogram ☐ Lab Results ☐ CT Scan/CTA

☐ Cardiac Catheterization ☐ Holter/Event Monitor ☐ Billing Records

☐ Other: _____

Date(s) of service / date range: _____

PURPOSE OF DISCLOSURE

☐ At my request ☐ Continuing care ☐ Insurance/benefits ☐ Legal ☐ Other: _____

DELIVERY METHOD

☐ Fax ☐ Secure Email ☐ Mail ☐ Patient Pickup ☐ Electronic Transfer

EXPIRATION

This authorization expires on (date) _____ OR upon this event: _____

AUTHORIZATION STATEMENTS

By signing, I give permission to the health care entity named above to disclose the health information identified on this form to the recipient named above. I understand that, except where specifically permitted by law, treatment or payment may not be conditioned on my signing this authorization.

I understand that I may revoke this authorization in writing at any time by delivering the revocation to the person or entity in possession of my health records. A revocation will not affect disclosures already made in reliance on this authorization.

I understand that information disclosed under this authorization may be redisclosed by the recipient and may no longer be protected to the same extent by federal or state privacy law. I understand that I am entitled to a copy of this signed authorization.

Patient Signature:

Date:

IF signed by patient representative:

Representative Name:

Relationship to Patient:

Representative Signature:

Date: