DIAGNOSTIC CARDIOLOGY ASSOCIATES, P.A.

Patient Medical Records Release Form

Patient Name _____ Date of Birth _____

Address _____

_____

Phone Number _____ Social Security Number _____

I hereby authorize Diagnostic Cardiology Associates, P.A. to release/request the following information contained in my medical records.

This is a ___ One-Time Disclosure ___ Continuous Disclosure for 12 months beginning _____
All PHI including confidential All PHI except confidential selected below*

(*Note: While specific Confidential PHI will not be included, the information authorized for release may make reference to confidential findings.)

___ Lab Reports
___ X-ray Reports
___ Sexual Abuse Information
___ Sexually Transmitted Diseases (STD)
___ Drug and Alcohol Abuse Information
___ Child Abuse and Neglect
___ Psychiatric Information
___ AIDS / HIV
___ Other (please specify) _____

Release of PHI is for: ___ Attorney ___ Physician ___ Insurance
___ Other (please specify) _____

Mail to (Name and Address): _____

_____

_____

_____

I understand that I may revoke this authorization in writing at any time, except to the extent that the release has been made prior to my revocation in reliance on this authorization and that such release shall not constitute a breach of my right to confidentiality. unless I otherwise revoke this authorization in writing it shall expire on the following date, event, or condition: _____

_____.

At that time no express revocation shall be needed to terminate my authorization. I hereby release Diagnostic Cardiology Associates, P.A. from any legal responsibility or liability for disclosures that may arise as result of the use of the information contained in the PHI released.

I acknowledge that I have read this authorization and fully understand its contents.

Signed: _____ _____
Patient, Parent or legal Representative Date

Witness: _____ _____
Date

Employee Name: _____ Date Received: _____

*Treatment or payment may not be conditioned on obtaining authorization for release of PHI.
**Patient should understand that by releasing PHI, the patients PHI might be subject to re-disclosure.
***Employee receiving this revocation must fill out the following information and then place the signed original in the designated place in the patient's chart under the Authorization tab.

___ Mail records ___ Pick up records ___ Telephone for instructions _____