Eastern Cardiology, PA
AUTHORIZATION TO RELEASE HEALTH INFORMATION

Patient Name: _____ Date of Birth: _____ Chart Number:_____

Information to be disclosed/released: (Check information to be disclosed/released)

☐ Office Visit Notes ☐ Laboratory Results ☐ Diagnostic Reports ☐ Procedure Reports ☐ Radiology Reports

☐ Other (please specify): _____

Purpose: ☐ Continuity of Care ☐ At the Request of the Individual ☐ Transfer of Care ☐

Legal/Insurance ☐ Other: _____

****Purpose is not required if patient is obtaining a copy of the record for his/herself.**

Authorization: I request and authorize Eastern Cardiology to: ☐ send/provide records/information to ☐ receive records/information from

Facility/Individual: _____ Phone: _____

Address: _____

City: _____ State: _____ Zip Code: _____

Fax Number: _____

This information will cover the period(s) of healthcare from _____ to _____.

Date **Date**

Format to be sent: via ☐ Hard Copy ☐ Fax ☐ Mail ☐ Email _____

I understand sending email over the internet is not secure. I understand there is a possibility that information included in an email can be intercepted and read by others beside the person whom it is addressed. I have been informed of the risks and still wish the information to be provided via email to the address noted above.

I understand this authorization can be revoked by writing to the Eastern Cardiology, P.A. Privacy Officer or filling out a form (Ref. FM0018) at any time, except to the extent that action has been taken in accordance with this authorization. **Unless otherwise revoked, this authorization will expire in:**

☐ **90 days;** ☐ **one year;** ☐ **other: (can not exceed one year) _____.**

If I fail to specify an expiration date, this authorization will expire one year from the date on which it was signed.

I understand authorizing the use or disclosure of the information identified above is voluntary. I need not sign this form to ensure healthcare treatment. I understand information released may be related to HIV/AIDS, communicable/sexually transmitted diseases, drug testing information, mental health, substance and/or alcohol use, treatment for abortion and/or contraceptive management or genetic testing. The facility, its employees, officers and physicians are hereby released from any legal responsibility or liability for disclosure of the above information to the extent indicated and authorized herein. I also understand that, if the person or entity receiving this information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by these regulations. However, the recipient may be prohibited from disclosing substance abuse information under the Federal Substance Abuse Confidentiality Requirements. All requests will be handled within 30 days.

Patient Signature: _____ Date: _____

Personal Representative Signature (if not the patient): _____ Date: _____

Printed Representative's Name: _____ Relationship to Patient: _____

Eastern Cardiology Representative Signature: _____ Date: _____

Printed Eastern Cardiology Representative Name: _____