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Authorization for Release / Request of Protected Health Information

Patient's Name, Date of Birth, Address, SS # (optional), Patient's Phone Number, Date of Request, Date Needed

I authorize Huntsville Cardiovascular Clinic, P.C. to release information to: OR I authorize Huntsville Cardiovascular Clinic, P.C. to obtain information from: Name of Provider, Facility or Other, Address, City, State, Zip Code, Phone # / Fax # (include area code)

Purpose For This Request: (Please Check One) [] Healthcare [] Insurance Coverage [] Personal [] Other

Type of Records Requested: (Check One or More) [] Physician's Orders [] Progress Notes [] EKG Report

[] Imaging Results [] Echo Report [] History & Physical [] Stress Test [] Hospital Records

[] Other

[] All Medical Records

AUTHORIZATION VALID FOR THIS REQUEST ONLY

I understand that:
• The information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
• I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. The revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
• Once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
• Unless otherwise revoked, the authorization will expire on the following date, event or condition:
If I fail to specify an expiration date, event or condition, this authorization will six months from the date of signing.

Signature of patient or legal representative

Date

If signed by legal representative, relationship to patient

Signature of Witness Date