

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.)

<input type="checkbox"/> Lab Reports	<input type="checkbox"/> X-ray Reports
<input type="checkbox"/> Sexual Abuse Information	<input type="checkbox"/> Sexually Transmitted Diseases (STD)
<input type="checkbox"/> Drug and Alcohol Abuse Information	<input type="checkbox"/> Child Abuse and Neglect
<input type="checkbox"/> Psychiatric Information	<input type="checkbox"/> AIDS / HIV
<input type="checkbox"/> 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 _____