Montgomery Cardiology LLC

AUTHORIZATION TO DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Full Name ____

DOB ____________________________________ Phone number _____________________________________

1. **Entity who is authorized to release Patient's information:**

   Name _Montgomery Cardiology LLC___________ Fax __301-610-4007__________ Phone _301-610-4000 ___

2. **Entity to whom the Patient's information may be disclosed (Where the records will be going.)**

   Name ____

   Address____

   Phone ___________________________________ Fax ____

3. **The specific information that should be disclosed:**

   __________ LAST 24 MONTHS OFFICE NOTES/LABS/RECORDS _________ LAST 12 MONTHS OFFICE NOTES/LABS/RECORDS

   OTHER:

   ____

4. **The purpose for the disclosure is:** __Continuity of care____

5. **This authorization will expire on the following date or event:**

   ____

   If no expiration date is listed, the authorization will not expire.

WE PROVIDE THE PAST TWO YEARS OF RECORDS TO OTHER PROVIDERS (with a note to call if they need more) IF A PATIENT WANTS ARCHIVED RECORDS SENT TO THEMSELVES OR ANOTHER PROVIDER, THERE WILL BE COPYING FEES APPLIED.

Signed:

____ Date_________________________

Patient

____ Authority___________________________________

Personal Representative (parent, guardian, etc.)