Cardiovascular
& Heart Rhythm Associates, PA

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Authorization for Release of Protected Health Information

I authorize Cardiovascular & Heart Rhythm Associates, PA to request and receive my protected health information. Please choose from the following records to be released or requested.

- ☐ Complete Medical Record (includes all of the documents listed below)
- ☐ Diagnostic Imaging and Lab Results
- ☐ Procedure Reports, Discharge Summary (EKG, or any Cardiac-Related Procedures)

This information is being release or requested for the following purpose:

- ☐ Continuation of Care
- ☐ Attorney / Litigation
- ☐ Disability Services
- ☐ Insurance

I understand that I may revoke this authorization in writing at any time, except to the extent that action as already been taken based on this authorization. I understand that this form expires 180 days from the date of signature; unless specified in writing. I also understand that if the recipient authorized to receive information is not a covered entity (Ex: Insurance Company or non-health care providers). The released information may no longer be protected under federal and state privacy regulations.

To the party receiving information:
The confidential records being disclosed to you may be protected by Federal Loa. If so, federal regulations (42 CFR Part 2) prohibit you from making any further disclosures without specific written consent of the patient. A general authorization for the release of information is not sufficient for this purpose.

Patient Name: ____ Date of Birth: ____________________

☐ Requesting To: ☐ Requesting From:

Name____

Address: _____________________________________Phone: __________________Fax: ___________________

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Print Name Signature of Patient or Legal Representative Date