Premier Cardiovascular Institute

2901 North Claybourn
Avenue, Chicago, IL 60618

Phone: (773) 352-8881 Fax: (773) 352-7617

Consent For Release of Information

*****MAIL RECORDS IF MORE THAN 25 PAGES*****

Patient Name: _____ DOB:____/_____/_____

Patient Address:_____

Patient Phone:_____ SSN:_____-____-_____

I hereby freely and voluntarily authorize the following provider/facility:

Name:_____

Address:_____

Phone:_____ Fax:_____

Covering The Time Period from: _____/____/_____TO ____/_____
to release the following information from the health records of the above named patient to Premier Cardiovascular Institute for the purpose of continuation of care. (check below)

___ Complete Health Record
___ Specified Information from health record:_____
_____
___ Specific Imaging CD:_____

I understand this consent can be REVOKED at any time expect to the extent that disclosure made in good faith has already occurred in reliance on this consent. This consent will expire one year from the date signed below unless otherwise specified. I understand that I may revoke this consent at any time. It must be revoked in writing, addressed, and sent to Premier Cardiovascular Institute. The facility, its employees, officers and attending physician are released from legal responsibility or liability for the release of theabove information to the extent indicated and authorized for.

Signed:_____Date:____/____/_____

Witness:_____Date:____/____/_____