

CAPE CARDIOLOGY MD PC

125 UNDERPASS ROAD BREWSTER MA 02631

TEL: 508-876-3777 FAX: 888-275-9498

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

Thereby authorize <u>CAPE CARDIOLOGY MD PC</u> to those records to:	disclose my Protected Health info	ormation and to send
NAME OF ENTITY:		
ADDRESS:		
FAX:		
This authorization concerns the following medica	l information about me:	
Patient Name:		
Date of Birth:		
Address:		
I understand that my records are confidential and can when otherwise permitted by law. Information used o re-disclosure by the recipient and no longer protected may include but is not limited to history, diagnosis, and communicable disease, including HIV and AIDS.	r disclosed pursuant to this authoriza . I understand that the specified info	ation may be subject to rmation to be released
I understand that I may revoke this authorization in witaken in the reliance upon authorization.	iting at any time except to the exter	nt that action has been
taken in the renance upon authorization.		
Signature of Patient (18 years or older)	Date	_
Signature of Legal Representative	Relationship to Patient	 Date