CAPE CARDIOLOGY
125 UNDERPASS ROAD,
BREWSTER, MA 02631

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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize: _____
Name of Facility where patient was treated

to use and/or disclose the Protected Health Information to:

Cape Cardiology MD PC, 125 Underpass Road, Brewster, MA 02631
to continue my care with: Eleanor Sullivan, MD FACC.
Attn: Medical Record Department Fax: (888) 275-9498

Name: _____ _____ _____
Last First MI

Address: _____
Street (include Apt #, if applicable)

_____ _____ _____
City State Zip Code

Birth Date: _____ /_____ /_____ Telephone: (_____) _____

ALTERNATE ADDRESS: (Please indicate if the information is to be sent to a different address, that is other than the address listed above).

_____
Street (include Apt #, if applicable)

_____ _____ _____
City State Zip Code

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnosis, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in the reliance upon authorization.

_____ _____
Signature of Patient (18 years or older) Date

_____ _____ _____
Signature of Legal Representative Relationship to Patient Date