CAPE CARDIOLOGY MD PC

PO BOX 12
CENTERVILLE, MA 02632

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

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

I hereby authorize **CAPE CARDIOLOGY MD PC** to disclose my Protected Health information and to send those records to:

NAME OF ENTITY: _____

ADDRESS: _____

FAX: _____

This authorization concerns the following medical information about me:

Patient Name: _____

Date of Birth: _____

Address: _____

_____

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