AUTHORIZATION FOR THE RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Account #: _____
Date of Birth: _____

1. I authorize the use or disclosure of the above named individual's health information as described below.
2. The following individual or organization is authorized to make the disclosure:

CARDIOLOGY CONSULTANTS, PC
701 UNIVERSITY BLVD. E., STE. 400
TUSCALOOSA, AL 35401
Fax # 205-752-6244

3. **The type and amount of information to be used or disclosed is as follows**: (include dates where appropriate)
   [Check all that apply]
   - ❑ Problem list
   - ❑ Medication list
   - ❑ List of allergies
   - ❑ Immunization record
   - ❑ Most recent history and physical
   - ❑ Most recent discharge summary
   - ❑ Laboratory results from (date) _____ to (date) _____
   - ❑ X-ray and imaging reports from (date) _____ to (date) _____
   - ❑ Consultation reports from (date) _____ to (date) _____
   - ❑ Entire record

   Other: _____

4. I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
5. This information may be disclosed to and used by the following individual or organization:

Name: _____
Address: _____
Address: _____

For the purpose of: _____

6. I understand that I have the right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the medical records department at Cardiology Consultants, PC. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will **expire on the following date, event, or condition**:
   _____
   If I fail to specify an expiration date, event or condition, this authorization will expire in six months.

7. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR164.524. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact Denise Knox at 205-752-0694 extension 214.

_____ _____
Signature of Patient or Legal Representative **Date**

_____ _____
If signed by Legal Representative, Relation to patient **Signature of Witness**