AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient instructions: Complete all applicable sections, sign and date, and return this form to the cardiovascular/cardiology office.

1. PATIENT INFORMATION

Patient Full Name: _____	Date of Birth: _____
Address: _____	Phone: _____
City / State / ZIP: _____	Email: _____

2. RELEASE RECORDS FROM

Cardiology / Cardiovascular Office: _____	Provider / Physician: _____
Address: _____	Phone / Fax: _____

3. RELEASE RECORDS TO

American Cardiovascular Associates	Attention (if applicable): _____
Address: 121 Becks Woods Drive, Suite 202 | Bear, DE 19701	Phone / Fax: 302-207-5424 / 302-216-2467 or 302-216-0023
Email (if electronic): _____	Preferred delivery: ■ Portal ■ Email ■ Fax ■ Mail ■ Pick-up

4. RECORDS AUTHORIZED FOR RELEASE

■ Complete medical record ■ Cardiology office notes ■ Consultation reports
■ EKG / ECG reports ■ Echocardiograms ■ Stress-test reports
■ Cardiac catheterization / coronary angiography ■ Holter / event monitor reports
■ Lab results ■ Imaging reports / CDs ■ Medication list ■ Other: _____

Date range requested: From _____ To _____
Purpose of disclosure: _____

5. AUTHORIZATION & ACKNOWLEDGMENT

I authorize the release of the medical records identified above to the person or organization listed in Section 3. I understand that this authorization is voluntary and that I may revoke it in writing, except to the extent action has already been taken based on this authorization. I understand that records may contain information protected by applicable privacy laws and that the recipient may be subject to applicable restrictions on redisclosure.

Patient / Authorized Representative Signature: _____	Date: _____
Printed Name of Representative (if applicable): _____	Relationship to Patient: _____