HeartCare

HIPAA PRIVACY AUTHORIZATION/MEDICAL INFORMATION RELEASE FORM

We cannot discuss your health information with anyone other than yourself (including spouse) unless you provide us with authorization to do so. Please list below names of the individual/s you authorize our office to discuss care with.

This authorization includes appointment information, complete medical information including treatment plan and/or diagnosis, billing and claim information, and any other pertinent medical information contributed to my health care plan or treatment and care.

Designated Individual/s:

Name: _____ Relationship: _____

Name: _____ Relationship: _____

Name: _____ Relationship: _____

I authorize HeartCare to disclose/discuss my protected health information described above with the listed individual/s.

_____ _____

Print Name of Patient / Legal Representative *Date*

_____ _____

Signature of Patient / Legal Representative *Description of LR's Authority*

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