HeartCare

AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name: _____ D.O.B.: _____

Social Security Number: _____ Phone #: _____

Address: _____

City: _____ State: _____ Zip Code: _____

I authorize HeartCare to: ☐ Send my records to: ☐ Obtain my records from:

Name of Physician/Facility: _____

Address: _____

Phone #: _____ Fax #: _____

For the purpose of: ☐ Continued Medical Care ☐ Personal Use ☐ New Patient

Information to be released: _____

I understand that my records may contain information about alcohol or drug treatment, mental health, or psychiatric treatment and/or HIV/AIDS information. I do hereby expressly and voluntarily consent to the disclosure of my health information as specified, for the purpose or need as indicated above.

I understand HeartCare may utilize a medical record correspondence service and that there may be a fee assess for this service (Please allow 7-10 business days for records to be copied).

I understand this consent will expire 12 months after the date below, or when the information requested with this consent has been released. A photocopy of this authorization shall have the same effect as the original.

_____ _____

Print Name of Patient / Legal Representative *Date*

_____ _____

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