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PEDIATRIC
CARDIOLOGY
DIAGNOSTIC
CENTER

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

ATTN: MEDICAL RECORDS

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

I hereby request Pediatric Cardiology Diagnostic Center to provide me with my child's medical records.

Release to:
Name: _____
Relationship to Patient: _____
Address: _____
City/State/ZIP: _____
Phone/Fax/Email: _____

I understand that:
• My records may contain sensitive information (e.g., communicable disease, reproductive health, HIV/AIDS status, mental health, substance use) and I am authorizing their release.
• I may revoke this authorization at any time in writing, except to the extent the provider has already acted in reliance on it.
• Information released pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

Signature of Patient or Authorized Representative:

Signature: _____
Printed Name (if not patient): _____
Relationship to Patient: _____
Date: _____