A Three Rivers Cardiac Institute

Specializing in Cardiac, Thoracic and Vascular Surgery

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Authorization for Release of Protected Health Information

This authorization must be signed by the patient. If the patient is under 18 years of age, legally incompetent, or is unable to sign, the parent or guardian must provide authorization.

Patient Name ____ Date of Birth _____________________

Address ______________________________________City _____________________________

State _______ZIP: ____________ Phone No. ____________________ Medical Rec. #_____________

I hereby authorize: ____________________________***to*** **Release to / Obtain from**
(Party to release/receive the above named individual's health information :)

Name ____

Address ____

City ____________________________________State _____________ ZIP ______________

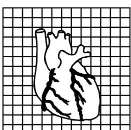
INFORMATION TO BE RELEASED/OBTAINED:

Entire record   Medication List   Most recent history & physical   Most recent discharge summary
X-ray and/or imaging reports from _____________(date) to _________________(date)
Consultation reports from (specify doctors' names/dates)______________________________
Other (please describe) ____________________________________

This information will be used for ______________________________________

- I understand that the information in my health record may include information relating to sexually transmitted disease, AIDS, or HIV. It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.
- I may revoke this authorization at any time by submitting a *written* notice of revocation. I understand that this notice cannot be revoked if records have already been released.
- I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure by the recipient and the information may not be protected by federal confidentiality rules.
- I may refuse to sign this authorization. My refusal will not affect my treatment or payment for my care.
- In the case of a minor child: I certify that no Court Order is currently in force that would prohibit my access to these records or prohibit my power to consent upon another person.
- In the case of a deceased patient: I, the undersigned next of kin, certify that I assumed responsibility for the disposition of the body of the deceased. There has been no probate of the decedent's Estate and there is no intent to enter the Estate into probate.
- Unless otherwise revoked, this authorization will expire on the following date, event or condition: ____
- (Will *automatically expire 1 year from the date of the patient's or personal representative's signature.)*

____ ________________
Signature of Patient or Personal Representative Date



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