

Authorization for Release of Health Information for Use by Heart Group of the Carolinas

Information to Be Used or Disclosed

Information to be obtained under this authorization includes:

Purposes of Disclosure

Information listed above will be disclosed for the following purposes:

Ongoing treatment and care for the patient and /or

Other reasons: _____

Information to be released From:

Facility Name: _____

Address: _____

City/State/Zip: _____

Information to be released To:

Heart Group of the Carolinas

Attn: Medical Records

307 Yadkin Street

Albemarle, NC 28001

Fax: 704-982-3260

Persons to Whom Information May Be Disclosed

Information described above may be disclosed to:

Heart Group of the Carolinas, PA (physicians and staff) Dr. _____

This authorization is effective for 120 days unless revoked or terminated by the patient.

Right to Terminate or Revoke Authorization

You may revoke this authorization by submitting a written revocation to Heart Group of the Carolinas.

Potential for Re-disclosure

Information that is disclosed under this authorization may be re-disclosed. The privacy of this information may not be protected under the federal privacy regulations.

Rights of the Individual

⊕ You may inspect or request a copy of information that is used or disclosed under this authorization.

⊕ You may refuse to sign this authorization. Signature is voluntary and will not effect your treatment.

Patient Name: _____ Date Of Birth: _____

Address: _____

City/State/Zip: _____ Social Security #: _____

_____ Date: _____

Printed Name of Patient or Authorized Representative

Patient or Authorized Representative Signature

If Authorized Representative, please indicate relationship to patient:

___ Spouse ___ Parent ___ Other: _____