Authorization to Release Confidential Medical Information

I, _____ DOB _____/_____/_____ SSN # _____/_____/_____

Address_____

City _____ State _____ Zip Code _____ Phone (_____)_____

authorize the party identified below to release the specified information to Cardiology Associates of Fredericksburg, 9530 Cosner Drive, Suite 200, Fredericksburg, Virginia 22408, (540) 373-1331; **fax (540) 373-1124**; for the purpose of continuing care.

Form must be filled out completely for records to be released.

Name _____

Organization _____

Address _____

City _____ State _____ Zip Code _____

Phone (_____)_____ Fax(_____)_____

Information to be Released/Obtained

Complete Chart*	_____	Laboratory Results	_____
H&P/Progress Notes	_____	Radiology Report	_____
Cardiac Testing/Imaging	_____	Drug & Alcohol*	_____
Cardiac Cath/Operative Reports	_____	HIV records*	_____
Final Discharge Summary	_____	Psychiatric Records*	_____

Other (please specify)

_____

***Complete chart request does not include psychiatric, drug and alcohol, or HIV records unless specifically requested on this form.**

Dates of Service _____ to _____

I hereby authorize, allow, and cause the release of information indicated above. No threat of utter coercive measures have induced me to sign this form, and I do so release Cardiology Associates of Fredericksburg from, and covenant not to sue Cardiology Associates of Fredericksburg for any claim I have or may in the future for the release of this information. I understand that I may refuse to sign this form and that my refusal to sign will not affect my ability to obtain treatment or payment or eligibility for benefits. I may request to inspect or copy any information used/disclosed under this authorization. I understand that if the person or entity that receives the information is not a healthcare provider or health plan covered by Federal privacy regulation, the information described above may be redisclosed and no longer protected by those regulations. I further understand that I may revoke this consent to release information at any time, except where actions have already been taken on the basis of this release. If I do revoke it earlier, this authorization will expire 6 months after the date specified below, or on the date, event or condition described as:

_____

Patient Signature_____ Date _____/_____/_____

Patient/Guardian/Patient Designee Signature _____ Date _____/_____/_____

Authority of Individual Signing for Patient _____

Witness Signature _____ Date _____/_____/_____