Premier Cardiovascular PA

2406 Blue Ridge Road, ste 150

Raleigh, North Carolina 27607

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Fax: 919-782-8302

1515 SW Cary Parkway, ste 200

Cary, North Carolina 27511

Phone: 919-387-1372

Fax: 919-387-1385

AUTHORIZATION FOR RELEASE OF INFORMATION

I Authorize: Premier Cardiovascular PA

To use or disclose to:

Name: _____

Address: _____

City: _____ State: _____ Zip: _____

Phone: _____ Fax: _____

The protected health information of:

Patients name: _____ Date of Birth: _____/_____/_____

Address: _____ City: _____ State: _____ Zip: _____

Mother's Maiden Name: _____

Treatment dates / Type of service: _____

Information to be disclosed: please (√) information requested):

	Face sheet		Nuclear procedure report		Discharge summary
	Consultations		Treadmill report		Physicians orders
	Medication		Stress ECHO report		Progress notes
	X-ray reports		Holter Monitor report		History & Physical
	Lab reports		Itemized Bills/ Statement		Catherization Report
	Emergency Dept notes		Other:		ECHO report

I acknowledge that the data released **MAY INCLUDE** material that is protected by law. My initials in the boxes below authorize the release (If applicable) of information pertaining to:

	Mental Health		Drugs & Alcohol		HIV / AIDS and other communicable diseases		Genetic Testing

The purpose of the use or disclosure is (please check (√) appropriate box):

	Attorney/Legal		Continued Patient Care		Social Services/Disability
	Personal use		Insurance		Other

I understand that:

- I may revoke this Authorization at any time.
- The revocation will not apply to information that has already been released in response to this authorization.
- The revocation will not apply to my insurance company and that the law provides my insurer with the right to contest a claim under my policy.

I understand that:

- If I revoke this authorization, I must do so in writing:
- The procedure for revoking this authorization is to present a written revocation to Premier Cardiovascular PA.

I also understand that.

- I may refuse to sign this Authorization.
- Premier cardiovascular PA will not condition the patient's treatment (or any payment, enrollment in a health plan, or eligibility for benefits) on receiving my signature on the authorization.

I have been informed and understand that information disclosed pursuant to this Authorization may be subject to redisclosure by a recipient of such information. It is possible that once disclosed, the privacy of the information will no longer be protected under federal medical privacy law.

I understand a fee may be charged for coping the protected health information.

Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____. If I fail to specify an expiration date of event or condition, this authorization will expire automatically in ninety (90) days of signature.

_____ Date: _____

Signature of Patient **-OR-**

_____ Date: _____

Signature of Authorized Representative

_____ Date: _____

Witness

Date completed: _____ Completed by: _____
Total pages: _____ Sent Via: Mail Courier Certified Mail Fax Pick up
Fax number: _____