CARDIOVASCULAR GROUP

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Phone: (770) 962-0399
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME	DATE OF BIRTH	LAST 4 DIGITS OF SS#	
ADDRESS	CITY	STATE	ZIP

RELEASE RECORDS FROM:

NAME OF DOCTOR/HOSPITAL			
ADDRESS	CITY	STATE	ZIP
PHONE	FAX		

RELEASE RECORDS TO:

NAME OF DOCTOR/HOSPITAL			
ADDRESS	CITY	STATE	ZIP
PHONE	FAX		

INFORMATION TO BE DISCLOSED:

DATES OF SERVICE: _____

- ❑ History and Physical
- ❑ Lab reports
- ❑ Discharge Summary
- ❑ Surgical Notes
- ❑ Clinic Records
- ❑ Echocardiogram
- ❑ EKG
- ❑ All Records
- ❑ Stress Test
- ❑ Radiology
- ❑ All Cardiac Testing
- ❑ Other: _____

PLEASE FAX RECORDS TO: _____ ATTN: _____

I understand that medical information may include if applicable*: Alcohol and/or drug abuse and/or mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II.* Information about Human Immunodeficiency Virus - HIV, acquired immunodeficiency syndrome - AIDS, and AIDS related complex - ARC, as defined by Department of Public Health rules (*1989 Public Act 174*). Third Party Information.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

- I understand that I may revoke this authorization at any time and that it will remain in effect for a period of 12 months from the date signed. This authorization pertains to fulfillment of the above stated purpose(s).
- I have read the above and acknowledge that I am familiar with and fully understand the terms and condition of this authorization.

_____ _____

SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

_____ _____

WITNESS DATE