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Acclaimed Heart and Vascular Center

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AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

I authorize Acclaimed Heart and Vascular Center ("AHVC") to ( ) release **TO** ( ) receive **FROM**

_____ _____
Person or Organization Address 1

_____ _____ _____
Phone Fax Address 2

Information / Medical Records on:

_____ _____ _____
Patients Name Date of Birth SS#

Date(s) of Service: ( ) All ( ) Dates _____

Information to be released:

( ) **ALL Cardiovascular and Medical Records**
( ) EKG REPORT ( ) LABS ( ) ECHO ( ) STRESS REPORT ( ) LAST NOTE
( ) CardioVascular Study Other_____

This information is being released for the following purpose (s):

( ) Medical / Continued Care ( ) Attorney / Litigation ( ) Insurance ( ) Disability Services
( ) Other_____

I understand that I may revoke this authorization in writing at any time, except to the extent that action has been taken in reliance on it and that in any event this authorization shall expire (365) days from the date of my signature, unless specified in writing here:_____. I understand that it may take up to 15 business days for the revocation to take effect I understand that if the recipient authorized to receive the information is not a covered entity, e.g. insurance company of non-health care provider; the released information may no longer be protected by the federal and state privacy regulations.

TO THE PARTY RECEIVING THIS INFORMATION:

This information has been disclosed to you from records whose confidentiality may be protected by federal law If so, federal regulations (42 CFR Part 2, and/or other applicable regulations/statutes) prohibit you otherwise permitted by such regulations. A general authorization for the release of information or other information is not sufficient for this purpose.

FOR PATIENT RECORDS APPLICABLE UNDER FEDERAL LAW 42 CFR PART 2 , and/or other applicable regulations/statutes)

_____ _____ _____
Signature of Patient or Legally Authorized Representative Driver's License / ID# Date

_____ _____
Printed Name of Patient or Legally Authorized Representative Relationship to Patient

_____ _____
Witness - Printed Name / Signature Date