Cardiovascular Medicine, P.C.

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For Office Use Only

Date received: _____ **ID verified by:** _____
Date processed: _____ **ID Method:** _____
Processed by: _____ **photo, visual recognition, other**
Date Delivered: _____ **Delivered by: faxed US mail picked up electronic**
Payment: □ $6.50 □ $10 □ $15 □ $25 □ Not applicable
Payment received by: _____ **Date:** _____

AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION

_____ _____ _____
Patient's full name Date of Birth Phone Number

I voluntarily authorize the disclosure of information from my records for the following purpose/s**: □ personal copy □ medical treatment □ insurance/disability □ legal matter □ research (may require special consent) □ discussing/coordinating of personal care with my personal representative □ other** _____

Information to be DISCLOSED BY:
Name: _____
Address: _____
City/State/Zip Code: _____
Phone: _____ Fax: _____

Information to be PROVIDED TO :
Name: _____
Address: _____
City/State/Zip Code: _____
Phone: _____ Fax: _____

The information to be disclosed from my health record: (check appropriate boxes)

- ☐ Entire record
- ☐ Only information related to (specify- echo, stress, office visit)_____
- ☐ Only records from _____to _____
- ☐ Other (specify)_____

***** The following types of information <u>WILL BE INCLUDED UNLESS</u> indicated by you initialing those that should not be included:**

_____ **Alcohol/Drug abuse treatment/referral** _____ **HIV/AIDS-related Treatment**
_____ **Sexually transmitted diseases** _____ **Mental Health**

** I understand that I have the right to inspect or copy the protected health information to be used or disclosed as permitted under federal law.
** I understand that I have the right to revoke this authorization, in writing, at any time to Cardiovascular Medicine, P.C., 1236 E. Rusholme St, Suite 300, Davenport, Iowa. 52803. I understand that such a revocation is not effective to the extent that Cardiovascular Medicine, has relied on the use or disclosure of the protected health information. If this authorization has not been revoked, it will terminate one year from the date of my signature unless I have specified a different expiration date or expiration event. _____(enter expiration date/event).
** I understand that Cardiovascular Medicine, will not condition treatment or eligibility for care on my providing this authorization except if such care is provided solely for the purpose of created Protected Health Information for disclosure to a third party.
** I understand that information disclosed by this authorization may be subject to redisclosure by the recipient and may no longer be protected by the Health Insurance Portability and Accountability Act Privacy Rule.
***** Payment:** There may be fees associated with some medical record requests. If your request requires a fee for processing, you will be contacted for pre-payment of the fee, prior to processing your request.

_____ _____
Signature of patient or patient's legal representative Date

_____ _____
Printed Name Relationship to patient (if other than patient)