# Authorization to Release Medical Records

Name of Patient _____ Date(s) of Service _____

Date of Birth _____ Social Security Number _____

I, the undersigned, authorize the release of, or request access to the information specified below from the medical record(s) of the above name patient.

INFORMATION TO BE RELEASED OR ACCESSED INCLUDES:

| | | | |
|---|---|---|---|
| Physician Notes( H&P, Consultation, Progress, Discharge) | | | EKG |
| Echo | Stress Test | Cath/PCI/EP | Chest |
| Xray | Labs | Cardiac Surgery | Other: _____ |

The above information may be released (specify name or title of the individual or the name of the organization to which records are to be released and the appropriate address):

TO:

**Athens Cardiac Clinic** **Phone: 706.850.3795**
**1360 Caduceus Way** ***Fax: 877.580.1676**
**Bldg 600, Ste 105**
**Watkinsville, Ga 30677**

FROM:

_____
(Doctor, Hospital, Attorney, Insurance Company, Self, etc.) Phone Number Fax Number

_____
Address (Street, City, State and ZIP)

I understand that my records are confidential and cannot be disclosed without my written authorization, except when otherwise permitted by law. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected. I understand that the specified information to be released may include but is not limited to history, diagnoses, and/or treatment of drug or alcohol abuse, mental illness, or communicable disease, including HIV and AIDS.

I understand that I may revoke this authorization in writing at any time except to the extent that action has been taken in reliance upon the authorization.

The authorization will expire six (6) months from the date of my signature, unless I revoke the authorization prior to that time.

Date: _____ Signature:_____
Patient or Legally Authorized Representative

_____
Printed Name of Patient or Legally Authorized Representative

_____ Relationship to Patient