ALABAMA CARDIOLOGY, P.C.

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BOARD CERTIFIED IN CARDIOLOGY, NUCLEAR CARDIOLOGY, ECHOCARDIOGRAPHY AND INTERVENTIONAL CARDIOLOGY
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RELEASE OF HEALTH INFORMATION

Patient's Name:	Date of Birth:
Address:	
City/State/Zip Code:	
SS#:	Patient's Phone #: ( )
Date of Request:	Date Needed:

□ I authorize Alabama Cardiology to release information to:	□ I authorize Alabama Cardiology to obtain information from:
Name of Provider or Facility	Name of Provider or Facility
Address	Address
City/State/Zip Code	City/State/Zip Code
Phone #/ Fax # (include area code)	Phone #/ Fax # (include area code)

Purpose For This Request: (Check One) □ Healthcare □ Insurance Coverage □ Personal □ Other
Type of Records Requested: (Check One)

□ Specific Information (Select one or more, as applicable)

- □ Operative report
- □ Laboratory test Results
- □ History and Physical
- □ X-Ray reports
- □ Cardio/Vascular Imaging
- □ Discharge Summary
- □ Angiogram CD
- □ Nuclear
- □ Other _____

□ All medical records related to a specific illness or injury
□ All medical records

_____
Specify illness/ injury Date(s) of treatment

AUTHORIZATION VALID FOR THIS REQUEST ONLY
I understand that:

- My right to healthcare is not conditioned on this authorization.
- I may cancel this authorization at any time by submitting a ***written*** request to the address provided at the side of this form, except where a disclosure has already been made in reliance on my prior authorization.
- If the person or facility receiving this information is not a health care or medical insurance provider covered by privacy regulations, the information stated above could be redisclosed.
- Release of HIV related information, mental health related care, or substance abuse diagnosis and treatment information requires additional authorization.
- There may be a charge for the requested records.

Note Medical records are faxed in case of medical necessity only.

Signture of Patient: _____Date:_____

Witness: _____