ASSOCIATES IN CARDIOVASCULAR DISEASE
MEDICAL RECORD SERVICES

AUTHORIZATION FOR RELEASE OF INFORMATION

I do hereby consent to and authorize the entity listed below to disclose to the person(s) named, information from my medical records relating to my treatment. This release is to be limited to the specified reports within the specified dates of treatment I have indicated below. I understand that this consent shall operate as a complete release of liability to the hospital and to its employees for the release of information as specified below.

To:_____ **Date:**_____
Patient Name:_____ **DOB:**_____
Phone:_____
Treatment Dates Needed:_____

Specified Reports: (Check appropriate space)

__ Abstract: face sheet, history & physical, discharge summary, operative report
__ All Medical Tests: labs, ekg, xray, echo, stress tests
__ Films
__ Other

Released to: Associates in Cardiovascular Disease (908) 464-4200 phone
571 Central Avenue, Suite 115 (908) 464-0915 fax
New Providence, New Jersey 07974 (908) 464-1332 fax

Special Instructions:_____
To be: Faxed__ Picked up__ Mailed__

I understand that once the entity listed above discloses my health information to the Recipient in accordance with the terms and conditions of this Authorization, the entity cannot guarantee that Recipient will not redisclose my health information to a third party. The third party may not be required to abide by this Authorization or applicable federal and state law governing the use and disclosure of my health information.

I have read and understand the terms of this Authorization and I have had an opportunity to ask questions about the use and disclosure of my health information. I hereby, knowingly and voluntarily, authorize entity listed above to use or disclose my health information in the manner described above.

_____ _____ _____
Patient Signature **Date** **Signature of Witness**

If individual is a minor or is otherwise unable to sign this Authorization, please complete the information below:

_____ _____ _____ _____
Signature of authorized Legal Guardian, Health Care Agent or authorized Personal Representative **Relationship** **Date** **Signature of Witness**

NOTICE TO RECIPIENT OF INFORMATION

Each disclosure made with the patient's written consent must be accompanied by the written statement reproduced below: This information has been disclosed to you from records protected by Federal confidentiality rules 42C.F.R. Part 2. The Federal rules prohibit you from making any further disclosure of this information unless further disclosure is expressly permitted by the written consent from the person to whom it pertains or as otherwise permitted by 42C.F.R. Part 2. A general authorization for release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.