Hope Cardiovascular Center

RECORDS RELEASE

DATE: ____

PATIENT: ____

BIRTH DATE: ____

THIS IS TO REQUEST AND AUTHORIZE:

FROM: ____

(Name of Doctor/Facility you are authorizing to release information)

____

Street City State and Zip

To release and/or disclose the medical information indicated below to the following healthcare provider/entity: ***This authorization is limited for the purpose of follow up treatment.***

TO: ____

(Name of Doctor/Facility to whom you want information sent)

____

Street City State and Zip

CHECK RECORDS TO BE RELEASED:

____ All Medical Records ____ X-Rays ____ Lab Work

____ Operative Reports ____ Discharge Summary ____ H & P

____ Other: ____

This authorization shall become effective immediately and shall remain in effect until ____________ or unless revoked in writing by myself at any time prior to the release of information. This information has been disclosed from records whose confidentiality is protected by Federal Law. I understand that the requester may not lawfully further use or disclose the health information unless another authorization is obtained from me or unless disclosure is specifically required or permitted by law. I further understand that I have the right to receive a copy of this authorization upon my request.

SIGNATURE: ____

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