



# CARDIAC SURGERY ASSOCIATES, S.C.

## Authorization to Release Medical Records

### Part A: Individual for whom medical records are being requested.

First Name: \_\_\_\_\_ Middle Name: \_\_\_\_\_ Last Name: \_\_\_\_\_  
 Date of Birth: \_\_\_\_\_ Previous Name (if applicable): \_\_\_\_\_  
 Street Address: \_\_\_\_\_  
 City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
 Home Phone: \_\_\_\_\_ Cell Number: \_\_\_\_\_

### Part B: Person/Organization from whom medical records are requested.

Organization's/Physician's Name: \_\_\_\_\_ Attention: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Part C: Send requested medical records to:

Organization's/Physician's Name: \_\_\_\_\_ Attention: \_\_\_\_\_  
 Address: \_\_\_\_\_  
 Phone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Part D: Information to be disclosed from dates: \_\_\_\_\_ (Range of dates) Treatment Occurring From \_\_\_\_\_ to \_\_\_\_\_

<input type="checkbox"/> Consultation Reports	<input type="checkbox"/> Pathology Reports	<b>Diagnostic Test Reports:</b>	
<input type="checkbox"/> Discharge Summary	<input type="checkbox"/> Progress Notes		<input type="checkbox"/> Include CD-ROM with images for the following:
<input type="checkbox"/> Emergency Department Record	<input type="checkbox"/> Social History		<input type="checkbox"/> Cardiac Catheterization Reports
<input type="checkbox"/> History and Physical	<input type="checkbox"/> Ultrasound Report		<input type="checkbox"/> CT/CTA/MRI/MRA Reports
<input type="checkbox"/> Lab Results	<input type="checkbox"/> X-Ray Report		<input type="checkbox"/> Peripheral Angiograms
<input type="checkbox"/> Operative Reports			<input type="checkbox"/> PET/CT Reports
<input type="checkbox"/> Other: _____			

### Part E: Purpose of Disclosure. Check reason(s) for the release of medical records.

Itemized Billing       Insurance Medical Chart Auditing       Attorney's Office  
 Continuation of Care       Other (explain): \_\_\_\_\_

### Part F: Expiration of Authorization.

This authorization is valid until calendar date: (Month/Day/Year) \_\_\_\_\_  
 This authorization will expire 12 months from date of signature below.

### Part G: Release of Highly Confidential Information and Signature:

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

**By checking any of the following category of Highly Confidential Information below, I specifically authorize the use and/or disclosure of the category of Highly Confidential Information indicated next to the box:**

**(Please check all that apply-leaving a box unchecked may result in no information being disclosed for any purpose.)**

<input type="checkbox"/> Abuse of an Adult with a Disability	<input type="checkbox"/> Mental Illness or Developmental Disability	<input type="checkbox"/> Sexual Assault
<input type="checkbox"/> Child Abuse and Neglect	<input type="checkbox"/> Substance Abuse (i.e., alcohol or drug)	
<input type="checkbox"/> Genetic Testing	<input type="checkbox"/> Sexually Transmitted Diseases (STD's)	



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HIV/AIDS Testing or Treatment (including the fact that an HIV test was ordered, performed or reported, regardless of whether the results of such tests were positive or negative).

**Name of Individual for whom medical records are being requested:**

**Part H: Signature.**

Only medical records originated through this healthcare facility will be copied unless otherwise requested. This authorization is valid only for the release of medical information dated prior to and including the date(s) stated above in Part D on this authorization unless other dates are specified.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed, as provided in CFR 164.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to Cardiac Surgery Associates, S.C. or whomever I gave my written authorization to. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event, or condition: \_\_\_\_\_. If I fail to specify an expiration date, event, or condition, this authorization will expire 1 year from the date signed.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

Signature of Individual: \_\_\_\_\_ Date: \_\_\_\_\_

Signature of Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Authority to represent individual:  Legal Guardian  Power of Attorney  Legal Representative

By signing this Authorization as a Legal Guardian, by Power of Attorney, or by being a Legal Representative, I agree I will provide written proof that I am Legally Authorized to act in respect to this Authorization.

Signature of Witness: \_\_\_\_\_ Date: \_\_\_\_\_

**Part I: Revocation Section.** If completed, send copy of entire form to Person/Organization named in Part B.

I no longer want health information pertaining to the person named in Part A shared with \_\_\_\_\_. I understand action already taken before the revocation is received is not affected.

Signature of Individual/Authorized Representative: \_\_\_\_\_ Date: \_\_\_\_\_

Authorized Representative:  Legal Guardian  Power of Attorney  Legal Representative