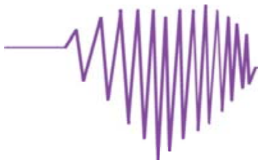


CARDIAC SURGERY ASSOCIATES, S.C.

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) From _____ to _____

- ☐ Consultation Reports
- ☐ Discharge Summary
- ☐ Emergency Department Record
- ☐ History and Physical
- ☐ Lab Results
- ☐ Operative Reports
- ☐ Pathology Reports
- ☐ Progress Notes
- ☐ Social History
- ☐ Ultrasound Report
- ☐ X-Ray Report

Diagnostic Test Reports:

- ☐ Include CD-ROM with images for the following:
- ☐ Cardiac Catheterization Reports
- ☐ CT/CTA/MRI/MRA Reports
- ☐ Peripheral Angiograms
- ☐ PET/CT Reports

☐ Other: ____________

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

- ☐ Attorney's Office
- ☐ Continuation of Care
- ☐ Insurance Medical Chart Auditing
- ☐ Other (explain): ____________
- ☐ Itemized Billing

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:

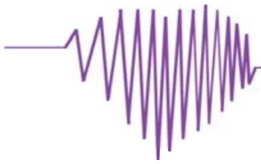
I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and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

- ☐ Abuse of an Adult with a Disability
- ☐ Child Abuse and Neglect
- ☐ Genetic Testing
- ☐ Mental Illness or Developmental Disability
- ☐ Substance Abuse (i.e., alcohol or drug)
- ☐ Sexually Transmitted Diseases (STD's)
- ☐ Sexual Assault

☐ 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).



CARDIAC SURGERY ASSOCIATES, S.C.

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. 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: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Authorized Representative

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: ☐ Parent ☐ Guardian ☐ Power of Attorney ☐ Authorized Representative