



PEDIATRIC

CARDIOLOGY ASSOCIATES

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Release of Information Authorization Form

I authorize the use/disclosure of health information about me as described below:

1. Who would you like to **release** the information? [Print name and address]:

2. Who would you like to **receive** the information? [Print name and address]:

3. Description of information that may be used/disclosed:

4. The information will be used/disclosed for the following purposes (**not required for patient releases**):

5. I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal privacy regulations, the information described above may be redisclosed and no longer protected by those regulations

6. I understand that the Practice **releasing** the health information may receive compensation for its use/disclosure of the information.

7. I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization (**not required if the disclosure is requested by the patient**).

8. I understand that I may revoke this authorization in writing at any time by submitted documentation to the practice except to the extent that action has been taken in reliance on this authorization. This authorization expires one year from the date signed unless otherwise directed.

9. Requests for copies of medical records will be at a fee of .75 per page unless sent directly to a provider for coordination of care.

Signature of Patient or Representative

Date

Patient's Name (Please Print)

Date of Birth

Name of Personal Representative (if applicable)

Relationship to Patient