Authorization for Release of Information

PATIENT NAME: ____ DATE OF BIRTH: _____-_____-_____

ADDRESS: ____ SS#: _____-_____-_____

HOME PHONE: CELL PHONE

I hereby authorize ____________________________________to release information from my medical record as indicated below to:

NANTICOKE CARDIOLOGY, P.A.
200 FEDERAL STREET
SEAFORD, DELAWARE 19973

PHONE: **302-629-9099** FAX: **302-536-0053**

INFORMATION TO BE RELEASED:

	DATES:
❑ History and physical exam	_________________
❑ Progress notes	_________________
❑ Lab reports	_________________
❑ X-ray reports	_________________
❑ Other: _________________	_________________
______________________	_________________

I specifically authorize the release of information relating to:
❑ Substance abuse (including alcohol/drug abuse)
❑ Mental health (including psychotherapy notes)
❑ HIV related information (AIDS related testing)
X____
SIGNATURE OF PATIENT OR LEGAL GUARDIAN DATE

PURPOSE OF DISCLOSURE: ❑ Changing physicians ❑ Consultation/second opinion ❑ Continuing care
❑ Legal ❑ School ❑ Insurance ❑ Workers Compensation
❑ Other (please specify): ____

I understand that this authorization will expire on _______________days after I have signed the form. I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it. Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer be protected by Federal privacy regulations. I understand that if I am being requested to release this information by _________________________________ (Print Name of Provider) for the purpose of:
____
____

a. By authorizing this release of information, my health care and payment for my health care will not be affected if I do not sign this form.
b. I understand I may see and copy the information described on this form if I ask for it, and that I will get a copy of this form after I sign it.
c. I have been informed that _________________________________ (Print Name of Provider) ❑ will/ ❑ will not receive financial or in-kind compensation in exchange for using or disclosing the health information described above.

I understand that in compliance with Delaware statute, I will pay a fee of $______________ (Print the Fee Charged). There is no charge for medical records if copies are sent to facilities for ongoing care or follow up treatment.

_______________________________________ _________ OR ____ _________
SIGNATURE OF PATIENT DATE PARENT/LEGAL GUARDIAN/AUTHORIZED PERSON DATE

_______________________________________ __________ ____
RECORDS RECEIVED BY DATE RELATIONSHIP TO PATIENT