

THE HEART CLINIC, P.C.

AUTHORIZATION FOR THE RELEASE OF PATIENT INFORMATION

I hereby authorize the use or disclosure of my individually identifiable health information as directed below. I understand that this authorization is voluntary. I understand that if the organization authorized to received the information is not a health plan or healthcare provider, the released information may no longer be protected by Federal Privacy Regulations.

Patient Name: \_\_\_\_\_ DOB: \_\_\_\_\_

To From The Heart Clinic, P.C. at: 1700 Hospital South Drive, Suite 302, Austell, GA 30106
6095 Professional Pkwy., Bldg ,Suite 102, Douglasville, GA 30134

To From \_\_\_\_\_
Name of person, agency, healthcare provider, etc.

Address: \_\_\_\_\_

Information to be released: Entire record The following specific information:

For the purpose of: Referral/Second Opinion Disability Life Insurance Continuity of Treatment
Leaving Practice Other Reason: \_\_\_\_\_

Service Dates: From \_\_\_\_\_ to \_\_\_\_\_

I understand that my healthcare and the payment for my healthcare will not be affected by my signing this form.

I understand that I may see and copy the information described on this form if I ask for it, and that I may get a copy of this form after I sign it.

This authorization will expire on \_\_\_\_\_, or until all information has been received. I may revoke this authorization at any time except to the extent that it has already been acted upon.

I understand that The Heart Clinic, P.C. may charge me a fee for copying and mailing (or faxing) the requested information as set forth in The Heart Clinic, P.C. Fee Schedule and, if applicable, the fees have been discussed with me.

If your records are more than 3 years old, they may be stored in an off-site facility. If your request includes the entire chart, please note a \$30.00 retrieval service fee is charged to The Heart Clinic, P.C. and will be passed along to you, the patient.

I also understand that the records released may contain information pertaining to the diagnosis and treatment of a psychological/psychiatric illness, alcohol/drug abuse, Sickle Cell Anemia, Acquired Immunodeficiency Syndrome (AIDS) or AIDS related illnesses, or tests for or infection with the Human Immunodeficiency Virus (HIV). Send Do Not Send

Please send information via: Fax Mail Will Pick Up (date): \_\_\_\_\_

Signature of Patient or Legal Representative

Date

Witness

Date

The Heart Clinic at Cobb-Medical Records Dept.
Telephone: 770-739-0999
Fax: 770-739-0998

The Heart Clinic at Douglas
Telephone: 678-838-1249
Fax: 678-838-1257