CAPITAL HEART ASSOCIATES, P.A.

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AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **Date of Birth:** _____
Daytime phone number: _____

Complete all bolded sections

Select one of the following: □ Capital Heart to provide copies
□ Capital Heart to obtain copies from _____

Select one box in all sections:

A. Reason for Request: □ Continued Care □ Insurance □ Attorney □ Personal Use □ Other _____

B. Information Needed – not all may apply and a fee may be charged
□ Office Notes □ Echo/Stress Echo/Nuclear Test reports □ Lab Reports □ Operative Reports
□ Hospital Notes (only pertains to hospital notes that Capital Heart created)
□ Entire Medical Record □ Other _____

C. Date of encounter or visit: _____

D. Way to provide info: □ Paper copy □ CD (echo only) □ On-site Review (uncommon)

E. How to share information (choose one):
□ Pick Up Name of person picking up info: _____
□ Mail Name: _____
Address: _____
□ Fax Name: _____
Fax number with area code: _____

I understand the medical information to be disclosed may include information/results regarding psychological or psychiatric impairment, sexual assault, alcohol abuse, drug abuse, and/or a communicable disease including HIV/AIDS. I understand that I may revoke (cancel) this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. If I revoke this authorization, I must do so in writing to the Capital Heart Associates, P.A. Unless otherwise revoked, this authorization will automatically expire 90 days after the date signed. I understand that treatment will not be conditioned upon my completion of this authorization. I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by a recipient of such information and would no longer be protected under the terms of the federal privacy rule.

Patient Signature: _____ **Date Signed:** _____

When someone other than patient signs, the following must be completed:

I, _____ (print your name) hereby certify and attest that I am the duly authorized personal representative of the above patient, and I have the lawful authority to enter into this authorization on behalf of such individual. I understand proof of this authority may be requested. I have read the provisions set forth in this authorization, and agree that Capital Heart Associates, P.A. may disclose the medical information of such individual for the purposes set forth.

Signature of Representative: _____ **Date Signed**: _____
Relationship to Patient: □ Parent □ Guardian □ Executor of estate □ Power of Attorney □ Other _____
Reason patient unable to sign: _____

Remaining section to be completed by Capital Heart Associates Staff Only
Date Information Released: _____ Initials of who completed release: _____
Patient MRN: _____

Fax completed form to: Capital Heart – Medical Records, 919-881-0887
Or Mail completed form to: Capital Heart, Attn: Medical Records, 4201 Lake Boone Trail, Suite 104, Raleigh, NC 27607