6701 Airport Blvd, Bldg D, Ste 330, Mobile, AL 36608
3715 Dauphin St., Ste 1100, Mobile, AL 36608
1720 Springhill Ave., Ste 101, Mobile, AL 36604
188 Hospital Dr., Ste 100, Fairhope, AL 36532
1721 N. McKenzie St., Foley, AL 36535

Cardiology Associates

251-607-9797
251-607-7696 (FAX)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT CLEARLY

Patient Name: _____ Date of Birth: _____/_____/_____

Patient Address: _____ SSN (last 4 digits): XXX-XX-_____

City/State/Zip: _____ Phone: (_____)_____-_____

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization.

I authorize: _____

Phone: _____ Fax: _____

to release the below specified protected health information to:

Cardiology Associates - Attn: Medical Records

6701 Airport Blvd, Suite D330, Mobile, AL 36608

Fax Number: 251-607-7696

Purpose of this use and disclosure: _____

The specific information to be released is:

- ○ Last 2 office notes
- ○ Lab results
- ○ Echo reports
- ○ Stress test reports
- ○ Heart cath reports and diagrams
- ○ Cardiac operative notes
- ○ Vascular testing results
- ○ CT/CTA reports
- ○ Most recent device check
- ○ EKG
- ○ Electrophysiology testing results
- ○ PV procedure reports and diagrams
- ○ Other: _____

Date(s) of requested information: _____ or check for ☐ most recent.

Expiration date of this request: _____

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however that any revocation will be effective to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign this authorization.

_____ _____/_____/_____

Signature of Patient or Personal Representative Date

FOR OFFICE USE ONLY

Chart #: _____ Date received: _____

Date completed: _____ Completed by: _____