PREMIER HEART

## Authorization for Release of Information

| **Patient Name:** | **Date of Birth:** |
|---|---|

| **Address:** | | |
|---|---|---|
| **City:** | **State:** | **Zip Code:** |

**I authorize the use or disclosure of the above-named individual's health information as described below.**

| **Treatment Dates:** |
|---|

**Rendering Facility or office:** _____
**Address:** _____
_____
**Phone:** _____
**Fax:** _____

The type of information to be used or disclosed is as follows:

| | | | |
|---|---|---|---|
| _____ Treatment/ visit notes | _____ EKG | _____ Reports | _____ Medication lists |
| _____ Lab results | _____ Radiology Reports | _____ Consult notes | _____ Other |

**This information may be disclosed to and used by the following individual or organization:**

**Premier Heart, LLC**

**151 Fries Mills Road, Suite 105**

**Turnersville, NJ 08012**

**Office: 856-212-0130 Fax: 856-212-0135**

I understand that information in my health record may include information relating to Human Immunodeficiency virus (HIV), AIDS (Acquired Immune Deficiency Syndrome), psychological or psychiatric conditions or treatment, sexually transmitted diseases or drug/alcohol, abuse/ dependence status, detoxification or rehabilitation services. I understand that I have the right to revoke this authorization at any time. I understand if I revoked this authorization I must do so in writing and present my revocation to Premier Heart. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy. Unless otherwise revoked, this authorization will expire on the following date, event or condition_____. If I fail to specify an expiration date, this authorization will expire in 1 year. I understand that authorizing the disclosure of health information is voluntary and I can refuse to sign the form if I do not wish this request processed. I do not need to sign this form to assure treatment. I understand I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules.

**Signature of Patient or Legal Representative**: _____ Date: _____

If signed by legal representative, relationship to patient: _____