HEARTCARE GROUP

1249 S. Cedar Crest Boulevard – Allentown, PA 18103-6259 – 610-770-2200 – Fax: 610-770-2990

MEDICAL INFORMATION RELEASE

PATIENT NAME	SOCIAL SECURITY NUMBER	DATE OF BIRTH
PATIENT ADDRESS		PHONE NUMBER

I, _____, do hereby consent to and authorize **THE HEART CARE GROUP, P.C.** to disclose to/obtain from:

NAME OF DOCTOR/HOSPITAL/INSURANCE COMPANY/OTHER AGENCY:

_____

ATTENTION: _____

ADDRESS: _____

FOR THE PURPOSE OF: _____

Information from my record relating to my identity, diagnosis, prognosis, or treatment may be released. However, I do not give permission for any other use or redisclosure of this information:

ATTENTION PATIENT

Please be alerted that, if any one of the following three (3) boxes is checked, it is with the intention of making you aware that your record(s) contains "PROTECTED" information related to these categories. Therefore, your signature next to the identified category acknowledges your awareness of this fact.
I further understand that there is specific documentation with my records which is protected under the

_____
SIGNATURE/DATE/TIME

☐ Drug & Alcohol Abuse Control Act 42 CFR Part 2

_____
SIGNATURE/DATE/TIME

☐ PA Mental Health Procedure Act

_____
SIGNATURE/DATE/TIME

☐ Confidentiality of HIV-Related Information Act, PA Law Act 148

I also understand that my record may contain:

- HIV-related information, if HIV-related tests were ordered by my physician;
- Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician;
- Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician.

The information to be released is:

☐ Face Sheet
☐ Office Note
☐ Procedural Reports
☐ EKG, Stress Test, Echo, Stress Echo
☐ Nuclear Studies
☐ EXCEPTION: I do not give permission to release (please specify):

☐ Laboratory Results
☐ Venous Studies
☐ Other (Please Specify)

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it is given.

I understand that my authorization will remain effective for a period of 90 days from date of discharge or date of my request.

_____
Patient Signature/Date/Time

_____
Witness to Signature/Date/Time

_____
Signature of Authorized Person/Date/Time

_____
Witness to Signature/Date/Time

Relationship: _____

☐ Unable to sign because: _____

PATIENT ☐ received ☐ refused a copy of this form. Date Information Released _____