AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

I UNDERSTAND THAT DEARBORN CARDIOLOGY WILL NOT CONDITION TREATMENT, PAYMENT, ENROLLMENT, OR ELIGIBILITY FOR BENEFITS ON MY PROVIDING OR REFUDING TO PROVIDE THIS AUTHORIZATION

Patient's Name: _____

Previous Name:_____

Date of Birth:_____ Date:_____

I request and authorize_____ to release healthcare information of the patient names above to:

Name:_____

Address:_____

City: _____State:_____Zip:_____

This request and authorization applies to:

☐ All healthcare information

☐ EKG ☐ All Cardiac Testing ☐ Recent Laboratory Results

☐ Hospital Care for the following dates: _____

Other: _____

REDISCLOSURE: I understand that the recipient may not lawfully further disclose the health information unless another authorization is obtained from me or unless use or disclosure is specifically required or permitted by law.

Patient Signature:_____ Date Signed_____

If signed by someone other than the patient, please indicate relationship:

_____

THIS AUTHORIZATION EXPIRES NINETY DAYS AFTER IT IS SIGNED

Patient has a right to a copy of this authorization. A copy is as valid as the original.