DEARBORN CARDIOLOGY

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AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

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

PATIENT NAME:_____

PREVIOUS NAME(S):_____

DATE OF BIRTH:_____SOCIAL SECURITY LAST 4 DIGITS: __ __ __ __

I REQUEST AND AUTHORIZE_____

FAX:_____ PHONE:_____

TO RELEASE HEALTHCARE INFORMATION OF THE PATIENT NAMED ABOVE TO:

DEARBORN CARDIOLOGY
5250 AUTO CLUB DR. SUITE 300, DEARBORN MI 48126

PHONE: (313) -724-9000 FAX: (313)-562-9300 (PREFERRED)

THIS REQUEST AND AUTHORIZATION APPLIES TO:

- ☐ ALL HEALTHCARE INFORMATION
- ☐ EKG
- ☐ ALL CARDIAC TESTING
- ☐ RECENT LABORATORY RESULTS
- ☐ HOSPITAL CARE
- ☐ 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:**_____

IF SIGNED BY SOMEONE OTHER THAN THE PATIENT, INDICATE RELATIONSHIP:_____

THIS AUTHORIZATION EXPIRES NINETY (90) DAYS AFTER IT IS SIGNED

PATIENT HAS A RIGHT TO A COPY OF THIS AUTHORIZATION. A COPY IS AS VALID AS THE ORIGINAL