MID AMERICA HEART, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION TO OUR PHYSICIANS

SECTION A: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

I hereby authorize the use or disclosure of my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization authorized to receive the information is not a health plan or health care provider the released information may no longer be protected by federal privacy regulations and may be re-disclosed.

PATIENT NAME: ____ DATE OF BIRTH: _______________

SOCIAL SECURITY NUMBER: ____________________________________ ID #: _______________________

Persons/Organizations providing information:

____
____
____
____
____

Persons/Organizations receiving the information:

Mid America Heart, P.C.
310 N. Seven Hills Road, Suite 150
O'Fallon, IL 62269-4111
618-632-1495

Specific description of information to be used of disclosed: _______________________________________
____
____

Patient must specify if any of these records are to be released:

[ ] Ob/Gyn [ ] Substance Use/Abuse [ ] HIV Testing/Treatment [ ] Psychiatric
[ ] Office Notes [ ] Cardiac Cath Reports [ ] Cardiac Cath Films [ ] Echo Results
[ ] Echo Tape [ ] Stress Results [ ] Holter Reports [ ] EKG
[ ] Laboratory [ ] Chest X- Ray [ ] Cardiac Surgery Reports [ ] All Medical Records
[ ] Hospital Admission/Discharge/ Consultation Notes (Cardiac Related)

Records needed: [ ] by appointment on ____________________ [ ] other: ______________________

Specific purpose for use or disclosure: ____
____
____

This Authorization is for information relating to the period from ______________________ to _____________

SECTIONS B: MUST BE COMPLETED FOR ALL AUTHORIZATIONS

1. The patient or the patient's representative must read the following statements and sign where indicated:

   a. I understand that my health care and the payment for my health care will not be affected if I do not sign this form.

   b. I understand that is may see and copy the information on this form if I ask for it, and that I get a copy of this form after I sign it.

2. I understand that this authorization will expire on _____/_____/_____ (In any event this authorization expires in 90 days after it is signed.)

3. I understand that I may revoke this authorization at any time by notifying the practice in writing, but if I do it will not have any effect on my actions taken before receipt of the revocation.

____ _ ______________________

Signature of Patient or Patient's Representative **Date**

I the authorizing signature is not that for the patient, indicate the legal relationship to the patient and legal basis on which consent I given for the patient ____

____ _______________________

Witness Signature **Date**

SECTION C: REVOCATION OF RELEASE MUST BE COMPLETED WHEN REVOKING PREVIOUS RELEASE AUTHORIZATION

I hereby revoke the authorization for release of information previously signed on _____/_____/_____. I understand that the practice may have made disclosures based on my previous authorization and that this revocation does not affect those disclosures.

____ ________________________

Signature of Patient or Patient's Representative **Date**

I the authorizing signature is not that for the patient, indicate the legal relationship to the patient and legal basis on which consent I given for the patient ____

____ _______________________

Witness Signature **Date**