

MID AMERICA HEART, P.C.
AUTHORIZATION FOR RELEASE OF INFORMATION FROM 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 or disclosed: _____

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

- | | | | |
|---------------------------------------------------------------------------------------------|-----------------------------------------------|--------------------------------------------------|----------------------------------------------|
| <input type="checkbox"/> Ob/Gyn | <input type="checkbox"/> Substance Use/Abuse | <input type="checkbox"/> HIV Testing/Treatment | <input type="checkbox"/> Psychiatric |
| <input type="checkbox"/> Office Notes | <input type="checkbox"/> Cardiac Cath Reports | <input type="checkbox"/> Cardiac Cath Films | <input type="checkbox"/> Echo Results |
| <input type="checkbox"/> Echo Tape | <input type="checkbox"/> Stress Results | <input type="checkbox"/> Holter Reports | <input type="checkbox"/> EKG |
| <input type="checkbox"/> Laboratory | <input type="checkbox"/> Chest X- Ray | <input type="checkbox"/> Cardiac Surgery Reports | <input type="checkbox"/> All Medical Records |
| <input type="checkbox"/> 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 _____
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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 I 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