MEDICAL RELEASE

PATIENT NAME:	DOB:
MEDICAL RECORD #:	SS#:

I authorize the following individual or organization to disclose the above named individual's health information:

NAME:
ADDRESS:
FOR THE PURPOSE OF:

Please release the following:

- ☐ Entire Records
- ☐ Problem List
- ☐ Progress Notes
- ☐ History/Physical Exam
- ☐ Medication List
- ☐ Immunization Records
- ☐ List of Allergies
- ☐ X-Ray/Imaging Reports from (date) _________ to ___________
- ☐ X-Ray Films
- ☐ Laboratory Results from (date) _________ to ___________
- ☐ EKG Reports
- ☐ Genetic Testing Information
- ☐ Diagnostic Reports (Specify): ________________________
- ☐ Other (Specify): ___________________________________

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

☐ **Yes,** I consent to the release of this information ☐ **No,** I do not consent to the release of this information

I understand that the information released is for specific purpose stated above. Any other use of this information without the written consent of that patient is prohibited.

I understand that I have the right to revoke this information at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to the individual or organization releasing information. I understand that the revocation will not apply to the information already released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to consent a claim under my policy. Unless otherwise revoked, this authorization expires upon completion of this request or upon the following date: ___________

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to ensure treatment. I understand that I may inspect or copy the information to be used or disclosed, as provided in CFR I64.524. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the Medical Records Custodian.

Signature of Patient or Legal Representative:	Date:
Relationship to Patient (If Legal Representative):	Witness:

COMPLETE ONLY IF INFORMATION IS TO BE RELEASED DIRECTLY TO PATIENT:

I understand that my medical records may contain reports, test results, and notes that only a physician can interpret. I understand and have been advised that I should contact my physician regarding the entries made in my medical record to prevent my misunderstanding of the information contained in these entries. I will not hold HEART INSTITUTE OF BROWNSVILLE, LLP, liable for any misinterpretation of the information in my medical record a result of not consulting my physician for the correct interpretation.

Signature of Patient or Legal Representative	Date:

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