

ARUNDEL HEART ASSOCIATES, P.A.
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Authorization for Release of Medical Records

Patient Information

Request Release from:

Date of Birth : _____

Social Security # : _____

I hereby authorize you to release to _____ a copy of my medical records to be used for continuing medical care. I reserve the right to revoke this authorization in writing at any time. Further, I understand that this Protected Health Information may be re-disclosed by the recipient and thus, no longer protected under privacy rules.

Patient or Guarantor Signature

Date

Please include the FOLLOWING ITEMS:

_____ Admission notes

_____ Progress notes

_____ Discharge summary

_____ Pathology reports

_____ Operative reports

_____ Consultations notes

_____ EKG'S

_____ Laboratory tests

_____ X-ray reports

_____ Stress tests

_____ Other _____

marks : _____

This authorization will expire on _____.