



Patient Authorization for Release of Protected Health Information

Patient Name: _____

Patient Record #: _____

Address: _____

Birth date: ____/____/____

SS#: ____-____-____

"I hereby authorize _____ (name of Practice) to release my Protected Health Information (information contained in my medical/financial records) to the following entity:"

Wilmington Cardiology, PLLC

Attn.: _____ (Medical Records Department)

1725 New Hanover Park Drive

Wilmington, NC 28403-5345

Phone: 910/815-3420

Fax: 910/815-3876

Description of Information to be Disclosed: _____

Purpose of Disclosure:	<input type="checkbox"/> Continuing Care	<input type="checkbox"/> Change of Doctor	<input type="checkbox"/> Workers Comp
	<input type="checkbox"/> Referral to Specialist	<input type="checkbox"/> Disability Determination	<input type="checkbox"/> Other: _____

To be read and signed by patient:

I understand the following:

1. I may revoke this authorization at any time by providing written notice to Wilmington Cardiology, PLLC
2. I may not be able to revoke this authorization once the practice has utilized the information received, or if the authorization was obtained as a condition of obtaining insurance coverage
3. Wilmington Cardiology, PLLC will not condition treatment or payment based on my signing this Authorization
4. The information disclosed by this authorization may be subject to redisclosure by Wilmington Cardiology, PLLC, and no longer protected by Federal Law
5. I have reviewed this Authorization, and understand its purpose and intent
6. I have received a copy of this Authorization
7. This Authorization is valid until/unless Patient/Representative submits to Wilmington Cardiology, PLLC a written request of revocation

x

Patient/Representative Signature

Date

Name (if other than Patient)

Office Use Only:

Date sent: _____ Mail Fax

Date Records Received: _____

Received by: _____