CardioVascular Consultants
"Caring for the hearts of our patients"

371 South Broadview Cape Girardeau, MO 63703 Phone # 573-334-6008 Fax # 573-334-1713

AUTHORIZATION FOR THE RELEASE OF HEALTH INFORMATION

_____	_____	_____	(____)_____
Patient Name	Social Security Number	Date of Birth	Contact Phone #

[ ] Please release my health information to my cardiologist at Cardiovascular Consultants:

My cardiologist's name is: _____

Please fax to (573)-334-1713 or mail to above address.

Physician/Facility name and/or fax number:
(Where the health information is coming from.)
→ _____
→ _____

[ ] Please release my health information from Cardiovascular Consultants to this individual/facility:

[ ] I am a patient wishing to pick up my health information at the facility.

(Please see fees and processing time below.)

_____
Individual/Facility

_____
Address

_____
City, State, Zip Code

_____
Phone Fax

Information to Be Disclosed:

[ ] Dates of Service: _____
[ ] Medical Records from the last two years
[ ] Complete set of Medical Records
[ ] Other: _____

Purpose of Disclosure:

[ ] Continuing Care (Primary Physician, other Physician, Specialist, etc)
[ ] Transfer of Care
[ ] Work-Related (Needed to return to work or for special work conditions)
[ ] Self (Please see fees below)
[ ] Other: _____

I authorize CVC to disclose the identified information to the persons and for the purpose described herein. I understand that, by signing this document, I release and discharge CVC from any liability and will hold CVC harmless for any release made pursuant to this Authorization. Unless revoked in writing, this Authorization will expire in 90 days from the date of my signature. If I do revoke this Authorization, it will not have any effects on any actions taken prior to receiving the revocation. I understand that once the information described is disclosed, it may no longer be subject to the privacy protections afforded by the facility if the recipient of the information is not a health plan, health care provider, health care clearinghouse, or a business associate that has contact with the facility.

I understand the following if I am requested records for my personal use:
I understand that if records are released to me personally, there will be a fee charged to me. I understand that this fee has been set by Missouri law. I understand that if I request records for my personal use, CVC's processing time of my request may take two to three weeks. I also understand that I may refuse to sign this Authorization, but if I do, I will not have access to my medical records. I understand that CVC will make every attempt to inform me when my requested records are ready to be paid for and picked up. Finally, I understand that I will not receive my records until I have paid for them in full.

There will be a search fee of $21.36 and an additional $0.50 per page for records requested by patients for personal use. Please allow at least one week for processing. This amount is subject to change according to Missouri law.

Please Note: We are happy to send records free of charge to any physician's office for continuing care purposes.

Legal Authority of person authorizing release of Health Information:
[ ] Patient
[ ] Representative/ medical power of attorney
[ ] Parent or Guardian
[ ] Administrator of deceased's estate

Signature _____

Print Name_____

Today's Date_____