Heart and Vascular Associates, LLC
130 Westmount Dr., Farmington MO 63640
Phone 573-756-1813 Fax 573-756-1868

Medical Record Release Authorization

Patient Name:_____ Maiden Name:_____ SS#_____

Date of Birth:_____ Home Phone:_____ Cell/Work: _____

Address:_____ City/State/Zip: _____

Email Address: _____

A) I hereby authorize records FROM:

Name_____

Address_____

City/State/Zip_____

Phone:_____ Fax:_____

B) To be released TO:

Name_____

Address_____

City/State/Zip_____

Phone:_____ Fax: _____

C) For the purpose of:

_____Litigation _____Disability

_____Insurance _____Work Comp

_____Self/Personal Copy _____Other

_____Transfer or Continuity of Care

Date Range_____ to_____

- ☐ Physician Office Notes
- ☐ Cardiology/EKG Reports
- ☐ Immunizations
- ☐ Lab/Path Reports
- ☐ Operative/Procedure Reports
- ☐ Radiology/XRay/MRI Reports
- ☐ Other _____
- ☐ Minimum Necessary

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 assure treatment. 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 authorized individual or organization making disclosure.

I understand that the information in my medical 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 drugabuse.

I understand that this authorization is value for up to 90 days. I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and present my written revocation to Heart and Vascular Associates, LLC. I understand that the revocation will not apply to information that has already been 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 contest a claim under my policy.

I have read the information provided on this release form and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

_____ _____

(Date) (Signature of Patient/Parent/Guardian or Authorized Representative)