



COASTAL CAROLINA CARDIOLOGY, P.A.

Coastal Carolina Cardiology, P.A.
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AUTHORIZATION TO RELEASE OF HEALTH INFORMATION

By signing this form, I authorize _____ /or _____
to use, release, or disclose the protected health information described below to:

Covering the periods of healthcare from _____ to _____.

The information to be disclosed shall be:

- | | | |
|---|---|--|
| <input type="checkbox"/> Complete health record (s) | <input type="checkbox"/> Office Visit Notes | <input type="checkbox"/> Consultation Report |
| <input type="checkbox"/> Laboratory results | <input type="checkbox"/> Diagnostic Reports | <input type="checkbox"/> Procedure Reports |
| <input type="checkbox"/> Cath Films | <input type="checkbox"/> General Correspondence | <input type="checkbox"/> Radiology |
| <input type="checkbox"/> Hospital Records (H&P, Discharge Summary, Cath Report) | | |
| <input type="checkbox"/> Other (please specify) _____ | | |

I give special permission to release information that may include:

- | | |
|---|---|
| <input type="checkbox"/> Acquired immunodeficiency syndrome (AIDS) | <input type="checkbox"/> Treatment for alcohol and/or drug abuse |
| <input type="checkbox"/> Sexually transmitted diseases | <input type="checkbox"/> Behavioral health service/psychiatric care |
| <input type="checkbox"/> Human immunodeficiency virus (HIV) infection | |

This information is to be released for the purpose of:

- | | |
|---|--|
| <input type="checkbox"/> Continuity of Care | <input type="checkbox"/> Insurance Coverage Limitation |
| <input type="checkbox"/> Transfer of Care | <input type="checkbox"/> Moving |
| <input type="checkbox"/> Referral | <input type="checkbox"/> Convenience |

I have been provided a copy of Coastal Carolina Cardiology's *Notice of Privacy Practices* and any charges that may be associated with this authorization. I have discussed any concerns I may have about the use, release, and disclosure, of my health information with Coastal Carolina Cardiology's Privacy Policy Officer or other appropriate office personnel.

I understand this authorization may be revoked in writing at any time, except to the extent that action has been taken in reliance on this authorization. Unless otherwise revoked, this authorization will expire 90 days after this authorization was signed by me. The facility, it's employees, officers, and physicians are hereby released from any legal responsibilities or liability for disclosure of the above information to the extent indicated and authorized herein.

Signature of Patient, Guardian, or Legal Representative
(State Your Relationship to the Patient)

DOB

DATE

(Witness) Form: 102-A
O: 4/13/03
R: 3/23/06

DATE