Heart and Vascular Care, Inc
Phone: 678-513-CARE (2273) Fax: 678-513-8869 www.hvcmd.com

Authorization to Release or Request Health Information

Last Name:_____ First Name:_____

Date of Birth: _____/_____/_____ Patient Phone #: _____ - _____ - _____

I hereby authorize Heart and Vascular Care, Inc. group to disclose medical and other information obtained in the course of my treatment and diagnosis. The information disclosed may be subject to re-disclosure and will no longer be protected by our privacy protection regulations.

I hereby release Heart and Vascular Care, Inc group from any liability, which may result from this disclosure of confidential information contained in the information released. I understand that I may revoke this authorization by providing written notice to the address on this form.

By signing below I:

1. Agree to pay copy charges if applicable for legal, insurance or personal use
2. Authorize any information requested to be faxed or mailed
3. Know the records may disclosed/include surgical, mental, substance abuse and HIV/AIDS information

Unless withdrawn, this consent will expire 1 year from the date signed

This information is to be released: ☐ To ☐ From
Heart and Vascular Care, Inc ~ 3970 Deputy Bill Cantrell Memorial Rd, Ste 100 Cumming, GA 30040

Purpose of the Request: ☐Continuing Care ☐Insurance billing ☐Legal ☐Other _____

Please send: ☐Last office note & Ekg ☐ All records ☐Billing records ☐Discharge records ☐Test/Labs

Treatment dates to be released: FROM: _____/_____/_____ TO: _____/_____/_____

Name:_____

Address:_____

Fax Number: _____ - _____ - _____ **Phone Number:** _____ - _____ - _____

Patient/Authorized Representative Signature:_____ Date:_____/_____/_____