6701 Airport Blvd, Bldg D, Ste 330, Mobile, AL 36608
3715 Dauphin St., Ste 1100, Mobile, AL 36608
1720 Springhill Ave., Ste 101, Mobile, AL 36604
188 Hospital Dr., Ste 100, Fairhope, AL 36532
1721 N. McKenzie St., Foley, AL 36535

251-607-9797
251-607-7696 (FAX)

AUTHORIZATION FOR USE AND DISCLOSURE OF PROTECTED HEALTH INFORMATION

PLEASE PRINT CLEARLY

Patient Name: ____ Date of Birth: ______________

Patient Address: ______________________________________ SSN (last 4 digits): XXX-XX-______

City: _____________ State: _______ Zip: ______________ Phone: ______________________

By signing below, you hereby authorize us to use or disclose information about yourself (or another person for whom you have the authority to sign) that is protected under federal law, for the sole purpose and time period described below. You may refuse to sign this authorization.

I authorize: _________________________ to release the below specified protected health information to:

☐ **Cardiology Associates** Attn: Medical Records 6701 Airport Blvd, Suite D330 Mobile, AL 36608 Fax Number: 251-607-7696	**OR**	☐ **To:** ______________________ Attn: ______________________ Address: ______________________ City, ST, Zip ______________________ Fax number: ______________________

Information to be used or disclosed (identified in a specific & meaningful fashion) ___________________________________

☐ Entire record ☐ Specific information: ____

☐ Patient Portal – Responsible party________________________ Email ______________________________

☐ Other _________________________________

The specific information to be released is:

- Last 2 office notes
- Lab results
- Echo reports
- Stress test reports
- Heart cath reports and diagrams
- Cardiac operative notes
- Vascular testing results
- CT/CTA reports
- Most recent device check
- EKG
- Electrophysiology testing results
- PV procedure reports and diagrams
- Other: ____

Information that **may not be** used or disclosed: ____

Date(s) of requested information: ___________________________ or ☐ Most recent

Expiration date of this request: _______/______/______

This information about you is protected under federal law, and you have the right to revoke this authorization in writing. Please be advised, however, that any revocation will be effective to the extent we have not already taken action in reliance on your authorization. By signing below, you recognize that the protected health information used or disclosed pursuant to this authorization may be subject to re-disclosure and may no longer be protected under federal law. We will not condition treatment based on your authorization. You may refuse to sign this authorization.

____ _______/______/______

Signature of Patient or Personal Representative Date

FOR OFFICE USE ONLY

Chart #: __________________________ Checked by: _____________________
Date received: ______________________ Date completed: _______________________ Completed by: __________________
Fee:__________ ☐ Paid ☐ Billed