Advanced Cardiovascular Clinic

6122 W Pierson Rd
Flushing, MI. 48433
Unit 1
(810) 600-3399
(810) 600-3398 Fax

PATIENT INFORMATION RELEASE AUTHORIZATION

I herby authorize Advanced Cardiovascular Clinic to use or disclose my individually identifiable protected health information as described below. I authorize the release of drug and alcohol records and/or records pertaining to communicable diseases, in accordance with Federal Regulations.

Patient's Name: _____
Date of Birth:_____

Requesting records from: ADVANCED CARDIOVASCULAR CLINIC, P.C **6122 W Pierson Rd**
Flushing, MI. 48433
Unit 1

Sending records to: _____
_____

Description of information that may be used or disclosed:

□ History and Physical Exam
□ Consultations/Progress Reports
□ Discharge Summary
□ Other: _____
□ Radiology/Laboratory Reports
□ Pertinent Information
□Complete Health Record

Purpose of Disclosure: _____

I understand that if the person or entity that receives the information is not a health care provider or health plan covered by federal or state privacy regulations, the information described previously may be re-disclosed and no longer protected by these regulations.

This authorization expires one year from the date in which I, or my legal representative, sign this authorization.

I understand that this authorization is voluntary and that I may revoke the authorization in writing to: Privacy Officer, 6122 W PIERSON RD FLUSHING MI 48433 UNIT 1. This authorization may not be revoked where the Practice has reasonably acted in reliance hereupon.

_____ _____
Patient's Signature Witness

Date: _____

Relationship to patient if not signed by patient:_____

Indicate why patient is unable to sign: ___Minor___Ward___Deceased___Other