Authorization To Release/Disclose Protected Health Information

Date: ___/___/___

To: ____

Fax: ____

I, ____, hereby authorize you to release and disclose the following medical records.

______All Medical Records (most common)
______Laboratory Reports
______Echocardiogram / EKG Reports
______Medication Records
______Clinical Notes
______Surgical Notes

Please send the requested records to the address below:

Elko Cardiology Associates 1784 Browning Way, Suite 1 Elko, NV 89801-8356
(775) 738-5100 – Phone (775) 738-5115 – Fax

I understand that this disclosure may include information regarding drug and alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Stature (42 CFR Part 2).

____ ____________________

Printed Patient Name **Date of Birth**

Address: ________________________________ ____________________

________________________________ **Last 4 digits of Soc. Sec. #**

____

Signature of patient (or authorized representative)

______________ __________________

Date of Signature **Relationship**

Date Authorization will expire: _____/_____/_____