Chart #:

Specialty Physicians Group, LLC d/b/a The CardioVascular Center

Authorization For Release of Information

For information about how your medical information may be used or disclosed, please see Patient Notice. You have the right to review the Notice before you decide to sign this form. The Notice is subject to change. You may request a copy of the Notice from the Privacy Officer.

- YOU HAVE THE RIGHT TO INSPECT, COPY, AND/OR AMEND INFORMATION TO BE USED OR DISCLOSED.
- YOU MAY REFUSE TO SIGN THIS FORM; HOWEVER, IT MAY PREVENT US FROM COMPLETING A TASK YOU HAVE REQUESTED (such as enrollment in research study or examining you to create a report for your attorney).
- WE WILL NOT CONDITION YOUR TREATMENT ON AN AUTHORIZATION, EXCEPT FOR AN AUTHORIZATION FOR RESEARCH-RELATED TREATMENT.
- WE MUST PROVIDE YOU WITH A COPY OF THIS AUTHORIZATION FORM UPON REQUEST.

This authorization is VOLUNTARY.

I, _____, (/ /), do hereby authorize **The Specialty Physicians**
(name) (date of birth)

Group, LLC d/b/a The CardioVascular Center to obtain, use, disclose, or receive my individually identifiable health information as described below. I understand that this authorization is voluntary. I understand that if the organization to which I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse, the released information may no longer be protected by federal privacy regulations.

I authorize release of information from my medical record (as outlined below):

Complete medical record that may contain treatment notes regarding radiology, pathology, immunization, procedure, and other common medical record documentation made by the physician, nurse, or other ancillary personnel.

For the purpose(s) of: **Continuity of Care**

I understand that I may withdraw my authorization in writing to the Privacy Officer of The Specialty Physicians Group, LLC at any time, except to the extent that action has been taken in reliance on this statement. I understand that even if I do not withdraw authorization, that this statement will expire **two (2) years from this date**. I have carefully read and understand the above, and do herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of my condition to those persons or agencies listed above.

_____ _____

Signature of patient or patient's representative **Date**

ATTENTION: PLEASE LIST THE INDIVIDUALS TO WHOM WE CAN COMMUNICATE:

_____

_____

_____

_____ _____

Signature of patient or patient's representative **Date**