Sutherland Cardiology Clinic

Methodist Healthcare

Authorization for Release to Methodist Healthcare

I, _____, do hereby authorize _____
Patient's Name *Agency or Individual*

_____
Address

to release to **SPG – SUTHERLAND CARDIOLOGY**

Medical information relating to my treatment in said facility for the following purpose only:

_____

The information released shall be limited to the following time period(s) or illness:

_____

Include also the following specific type data (check all that apply):

[ ] Discharge data [ ] X-ray [ ] EKG
[ ] History & Physical [ ] Clinic visits [ ] Lab
[ ] Operative Report [ ] E.D. Records [ ] All information in medical record
[ ] Verbal statements/conversations and letters regarding care

Expiration Date:

- The expiration date or expiration event for this authorization is **2 YEARS**
- If no expiration date or period is known it will expire six (6) months after the date recorded below.
- This authorization covers only treatment prior to the date recorded below.
- I understand I may revoke this authorization at any time with a written request to the Health Information Management Department of the above-named facility.
- The request to revoke authorization must contain the signature of the patient or the patient's legal representative and must be notarized.
- Revocation of this authorization is allowable only to the extent that the release of information has not already occurred and/or only if facility has not taken action in reliance thereon.
- I understand that treatment, payment, enrollment or eligibility for benefits may not be conditioned on obtaining this authorization.
- I further understand that any disclosure of records concerning diagnosis and/or treatment for alcohol or drug abuse is covered by Title 42 of the Code of Federal Regulations, and if there is any such information, I hereby authorize the release of this information.
- This authorization also includes any information related to diagnosis and/or treatment of any psychiatric or mental illness or any state of infection with the HIV (AIDS) virus.

Methodist Le Bonheur Healthcare and above noted facility is hereby released from all legal liability that may arise from the release of the information requested. Please note that information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under applicable federal law.

_____ _____
Signature of Patient or Authorized Individual Date

_____ _____
Relation if signed by Other than Patient Patient Social Security Number

_____ _____
Street Address Phone Number

_____ _____
City State Zip Code Date of Birth

Photo ID Provided_____yes_____no. If no, the form of patient ID must be stated _____

Witness Date _____

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