620 Stanton Christiana Road
Suite 203
Newark, DE 19713
(302) 338-9444
www.heartandvascularclinic.com

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Facility Releasing Information	Facility Receiving Information
The Heart and Vascular Clinic	________________________
Medical Records Department	________________________
fax# 302-994-9449	________________________

The purpose of this release of information is to provide continuity of my care, for processing an insurance claim or to meet another specific desire of mine. This information may ______, may not _______ include treatment for drug and/or alcohol abuse, psychiatric illness, HIV test results, or AIDS diagnosis, and/or other communicable diseases. I specify that this release is to include:

_____	Office Visit Summary	_____	History and Physical Exam
_____	Laboratory Report	_____	Consultation Report
_____	Radiology Reports	_____	Pathology Reports
_____	Immunization Reports	_____	Others. Specify Below

____

____

This authorization specifically pertains to information related to my treatment which occurred on the following dates: ______________________ to ______________________.

To assist in identification and location of my records, I am providing the following information.
Name used when treatment occurred: ____
Address given at that time: ____
____
____
____

Date of Birth: SSN#

This authorization expires 60 days from the below date, and it covers only treatment prior to that date.

X____
Patient or person authorized to consent for minor or patient who is unable to sign.

Date ________________________________ Witness ______________________________

NOTICE TO PERSON OR AGENCY RECEIVING INFORMATION: Federal and State Laws and regulations prohibit further disclosure of the information whose confidentiality is protected in the absence of a specific consent of the patient or person authorized to consent for the patient.