Hatfield CARDIOLOGY
46 North Street, Suite 6 Hyannis, MA 02601
Phone: 508-778-4888 Fax: 508-778-4887

AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

Patient Name:_____ **Date of Birth:**_____

Phone: H)_____ **Phone: W)** _____

Address:_____ **City/State/Zip:**_____

Above listed patient authorizes the following healthcare facility to make record disclosure:

Facility Name: Hatfield Cardiology, LLC **Facility Phone:** 508-778-4888

Facility Address: 46 North Street, Suite 6 **Facility Fax:** 508-778-4887

City, ST, Zip: Hyannis, MA 02601

Dates and Type of information to disclose:

☐ 2 years prior from last date seen
☐ Dates Other: _____
☐ Specific Information Requested:

_____

The purpose of disclosure is:

☐ Change of Insurance or Physician
☐ Continuation of Care (e.g., VA Med Ctr)
☐ Referral
☐ Other_____

I understand the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services, and treatment for alcohol and drug abuse.

This information may be disclosed and used by the following individual or organization:

Release To: _____

Address: _____

City, State, Zip: _____

Fax:_____ **Phone**_____

I understand I may revoke this authorization at any time. I understand that if I revoke this authorization I must do so in writing and present my written revocation to the health information management department. I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.

I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that I may inspect or obtain a copy of the information to be used or disclosed. I understand that any disclosure of information carries with it the potential for an unauthorized re-disclosure and the information may not be protected by federal confidentiality rules. If I have questions about disclosure of my health information, I can contact the authorized individual or organization making disclosure.

I have read the above foregoing Authorization for Release of Information and do hereby acknowledge that I am familiar with and fully understand the terms and conditions of this authorization.

X_____ _____

Signature of Patient / Parent / Guardian or Authorized Representative **Date**
(Guardian or Authorized Representative must attach documentation of such status.)

_____ _____

Printed name of Authorized Representative Relationship / Capacity to patient

_____

Address and telephone number of authorized representative