RELEASE OF INFORMATION AUTHORIZATION

I AUTHORIZE: ____

PHONE: ________________________________

FAX: ________________________________

TO USE OR DISCLOSE TO:

CAROLINA HEART CENTER, PA
PANKAJ N. PARIKH, MD
3406 SIX FORKS ROAD
RALEIGH, NC 27609
PHONE: (919) 881-7770
FAX: (919) 510-4600

THE PROTECTED HEALTH INFORMATION OF:

PATIENT NAME: ________________________________

MED REC #: ________________________________

D.O.B./SOC SEC# ________________________________

TREATMENT DATES/SERVICES: ________________________________

INFORMATION TO BE DISCLOSED:

↑ DISCHG SUMM ↑ CATH REPORT ↑ H&P ↑ ECG ↑ LAB REPORTS

↑ ____

THIS INFORMATION IS TO BE USED FOR PATIENT CARE PURPOSES.

I UNDERSTAND THAT:

✓ I MAY REVOKE THIS AUTHORIZATION AT ANY TIME. REVOCATION WILL NOT APPLY TO INFORMATION THAT HAS ALREADY BEEN RELEASED IN RESPONSE TO THIS AUTHORIZATION. REVOCATION WILL NOT APPLY TO MY INSURANCE COMPANY AND I UNDERSTAND THAT THE LAW PROVIDES MY INSURER WITH THE RIGHT TO CONTEST A CLAIM UNDER MY POLICY.

✓ IF I REVOKE THIS AUTHORIZATION, I MUST DO SO IN WRITING. THE PROCEDURE TO REVOKE THIS AUTHORIZATION IS TO PRESENT MY WRITTEN REVOCATION TO THE CAROLINA HEART CENTER, PA.

✓ I MAY REFUSE TO SIGN THIS AUTHORIZATION. CAROLINA HEART CENTER, PA WILL NOT CONDITION THE PATIENT'S TREATMENT ON RECEIVING MY SIGNATURE ON THIS AUTHORIZATION.

✓ THE INFORMATION DISCLOSED PURSUANT TO THIS AUTHORIZATION MAY BE SUBJECT TO REDISCLOSURE BY A RECIPIENT OF SUCH INFORMATION. IT IS POSSIBLE THAT ONCE DISCLOSED, THE PRIVACY OF THE INFORMATION WILL NO LONGER BE PROTECTED UNDER FEDERAL MEDICAL PROVACY LAW.

✓ UNLESS OTHERWISE REVOKED, THIS AUTHORIZATION WILL EXPIRE AUTOMATICALLY IN 90-DAYS FROM THE DATE OF THIS SIGNATURE.

____ ____

Signature of Patient/Guardian Date Witness Date