Release for Medical Records

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HEART SOUTH
CARDIOVASCULAR GROUP, PC

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Abilash Balmuri, M.D., FACC

Patient Name:_____

DOB:_____ M____ F____

I hear-by authorize _____

Phone:_____ Fax:_____

To release records to: **Heart South Cardiovascular Group, PC. Fax: 205-739-2049**

Information Needed:

Purpose of disclosure: _____ Changing Physicians _____Consultations/ Second Opinion _____Legal
_____Continue Care _____School _____Insurance _____Workers Compensation

Acknowledgements:

1. I understand that this authorization will expire 1 year after I have signed this form.
2. I understand that I may revoke this authorization at any time by notifying the providing organization in writing, and it will be effective on the date notified except to the extent action has already been taken in reliance upon it.
3. I understand that information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and no longer be protected by federal privacy regulations.

By authorizing this Release For Information form, my health care and payment for my healthcare will not be effected.

I understand I may view and receive copy(s) of the information described on this form provided that I ask for it and that I may get a copy of this form after I have signed it.

Patient Signature:_____ Date of Signature:_____