Release for Medical Records

1022 North First Street
Suite 500
Alabaster, AL 35007
O: 205-663-5775
F: 205-664-2112
heartsouthpc.com

HEART SOUTH
CARDIOVASCULAR GROUP, PC

John D. McBrayer, M.D., FACC
Mark L. Mullens, M.D., FACC
Clifton R. Vance, M.D.
David S. Fieno, M.D. Ph.D
Neeraj Mehta, M.D., FACC
J. Hudson Segrest, M.D.
Krishna Kishore Gaddam, M.D.
Himanshu Aggarwal, M.D.
Hosakote Nagaraj, M.D.
Nirman Bhatia, M.D., FACC
Patrick Proctor, M.D., FACC
Abilash Balmuri, M.D., FACC

Patient Name: _____ DOB: _____ M_____ F_____

I hereby 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 affected.

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: _____