Release for Medical Records

1022 North First Street
Suite 500
Alabaster, AL 35007
O: 205-663-5775
F: 205-664-2049
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
____ Continue Care ____ School ____ Insurance
____ Legal ____ 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 an 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: _____