

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION
PURSUANT TO PATIENT REQUEST**

1. Authorization. This shall serve as authorization for Cardiac Surgery Group to provide/release the information identified in section 2 below to:

2. Information to be Provided/Released. You are authorized to release my entire medical record or, if the following section is completed, only such portion of my medical records as are specifically described in the following space:

If this Authorization relates to someone other than the person signing it, indicate the name of the patient whose records are requested:

I understand that the records you release may contain information pertaining to the following:

Drug and alcohol abuse information	routine consultations/examinations
Information concerning HIV, including lab results	genetic testing and counseling
Diagnosis of AIDS or ARC	results of diagnostic testing
Diagnosis of sexually transmitted diseases	mental health information
History and physical	treatment recommendations

I understand that if I do not want any of the above information released, I may limit your authorization to release such information by crossing it out and initialing it. If there is other information that I specifically do not want released, I should identify it in the following space:

3. Purpose/Use of Information Requested. The information requested will be used for my own purposes or if not, then it will be used for the following:

4. Right to Revoke Authorization. I understand that I may revoke this Authorization at any time by notifying you in writing at the address set forth at the top of this page. I understand that if you have already released information or otherwise acted in reliance upon this Authorization, that any subsequent revocation will not affect the validity of your prior disclosure or other action.

I also understand that if this authorization was provided for purposes of obtaining insurance coverage, my revocation might give rise to the Insurer's right to contest a claim and/or to contest the validity of any insurance issued in reliance on the Authorization.

5. Termination. If not revoked by me sooner, this authorization will terminate on: _____.

6. Right to Inspect Information: I understand that I have the right to inspect the information to be disclosed.

Name

Signature

Date: _____

Relationship to Person Whose Records are Sought
(Such as Self, Guardian or Other Representative)