



Children's Cardiovascular Medicine P.C

AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Patient Name _____ Date of Birth: _____

Address: _____

Telephone Number: _____

I authorize: _____

NAME AND ADDRESS OF DOCTOR, HOSPITAL

PHONE NUMBER

FAX NUMBER

To release information to:

Children's Cardiovascular Medicine P.C.
61 Whitcher Street, Suite 4140 Marietta GA 30060
Phone: 404-943-0289 Fax: 404-943-9787

I authorize **Children's Cardiovascular Medicine P.C.** to disclose information contained in my medical record to:

PHYSICIAN NAME

CLINIC NAME

ADDRESS

CITY, STATE

ZIP CODE

PHONE NUMBER

FAX NUMBER

I understand that medical information may include if applicable:

Alcohol and drug abuse, mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II. Information about human immunodeficiency virus HIV, acquired immunodeficiency syndrome - AIDS, and AIDS related complex - ARC, as defined by Department of Public Health rules (1989 Public Act 174).

Specific information to be disclosed: (please include dates of treatment)

Lab Reports X-rays Discharge Summary
 Clinic Records EKG Stress Test
 Monitors reports All records for last two years

I understand that I may revoke this authorization at anytime and that it will remain in effect for a period of 12 months from the date signed.

This authorization pertains to fulfillment of the above stated purpose(s).

I have read the above, and acknowledge that I am familiar with and fully understand the terms and condition of this authorization.

 Patient's parent or guardian signature. (Must be the same we have on file)

 Date

 Witness

 Date