

AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION
Tri-City Cardiology Consultants, P.C.

Patient Name _____ Date of Birth _____

1) Please check (✓) one only:

I only want my medical information released to myself.

I give Tri-City Cardiology Consultants, P.C. and staff authority to release medical information regarding my care to the following individuals:

Individuals Name	Relationship to Patient
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2) Emergency Contact Name _____

Emergency Contact Phone Number _____

3) Please Initial below:

_____ Yes, I give my permission to leave messages regarding my test results, appointments, etc., at the following phone numbers _____, _____.

_____ No, do not leave messages regarding my test results, appointments, etc.

Patient Signature _____ Date _____

Witness _____

NOTE: The above authorization remains effective until patient notifies practice in writing of any change.

FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgment of receipt of this **AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION** but could not because:

Individual refused to sign Communication barrier Care provided was emergent Other: _____

Employee Name _____ Date _____