AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION

Tri-City Cardiology

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**
___________________________________	____
___________________________________	____
___________________________________	____

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.**

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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 ________________________

Updated 2.26.24