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) 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.

3) Emergency Contact Name _____

Emergency Contact Phone Number _____

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 _____ Date _____