cardionow

Consent to Release Protected Health Information

Authorized by: _____ Legal Guardian/DPOA: _____

Physician/Practice may disclose the following health information (Check that apply):

- ☐ All test results
- ☐ The entire medical record
- ☐ Today's chart note only

The following health information can not be disclosed (Check that apply):

- ☐ All test results
- ☐ The entire medical record
- ☐ Today's chart note only
- ☐ Other:

The purpose of the use/disclosure is (Check that apply):

- ☐ Continued medical care
- ☐ Employer's use
- ☐ Family/spouse's employer's use
- ☐ School use
- ☐ Other:

This authorization is in force until:

- ☐ One year
- ☐ It is revoked in writing

Disclosure to:

Spouse: _____

Children: _____

Others: _____

Okay to leave a voicemail at the following phone numbers: _____

_____ _____

Patient's Name (please print) DOB Date

_____ _____

Patient / Guardian Signature Relationship to patient