Authorization for Release of Protected Health Information

Patient Name at the Time of Treatment:	Date of Birth:
Street Address:	Social Security # :
City, State, Zip Code:	Telephone # :

I hereby authorize:

Coastal Cardiology
1033 St. Andrews Blvd.
Charleston, SC 29407
Phone (843) 723-6111 Fax (843) 723-0675

To release my "protected health information" to:

Physician / Practice	Telephone # :
Street Address:	Fax # :
City, State, Zip Code:	Additional Comments

___ Mail Record ___ I will pick up (If not specified, records wil be mailed)

Information for treatment period: From (Date) _____ To (Date) _____

Information to be released: (Please check all that apply)

___ Patient Identification /Diagnoses List
___ EKG/Cardiovascular
___ Pathology Reports
___ Pulmonary Function Test
___ Office Notes/Physician Dictation
___ Radiology Films Type _____
___ Physical therapy Records
___ Bill
___ Laboratory Test
___ Radiology Reports
___ Occupational Therapy
___ Other _____

This information is being requested for the following purpose(s): _____

_____.

Sensitive Information: I understand that my record may include information relating to acquired immuno-deficiency syndrome (AIDS), or HIV (Human Immuno-deficiency) infection, psychiatric care, psychological assessment, behavioral and/or mental health services. sexually transmitted diseases, alcohol and/or drug abuse and this information will be released.

Re-Disclosure: I understand that any disclosure of information carries with it the potential for re-disclosure and that the information must be in writing and that the revocation will not apply to information already released based on this information.

Right to revoke: I understand that I have the right to revoke this authorization at any time. I understand that my revocation must be in writing and that the revocation will not apply to information already based on this information.

Expiration: I understand that this authorization will expire 12 months after signed unless an earlier date is specified here _____.

Charges: I understand that there may be a charge for obtaining the requested information. The Copy Cat has been contracted to provide this service and will bill you directly. Questions may be directed to The Copy Cat at 843-819-7383.

_____ _____
Signature of Patient or Legal Representative Date

_____
Signature of Witness

_____
Description of Legal Representative's Authority (ATTACH NECESSARY DOCUMENTS)