Brookhaven Heart

Authorization to Release Protected Health Information

(Please complete, print, sign and bring at your visit)

Name: (*First, Middle, Last*)	Birth Date *(Month/DD/YYYY)*

Instruction: If any section is incomplete, this form may be invalid

Release Information From:	**Release Information To:**
□ Brookhaven Heart PLLC □ Other *(Specify facility/individual & address below, including phone/fax number if known)* _____ _____ _____	□ Brookhaven Heart PLLC □ Other *(Specify facility/individual & address below, including phone/fax number if known)* _____ _____ _____

Purpose of Release

□ Treatment/continued care	□ Personal	□ Disability Determination
□ Application for insurance	□ Legal purpose	□ Payment of insurance claim
□ Other		

_____

Information to be Released

Service Dates *(Optional)* From To	Information needed by *(Optional)*

□ Last visit notes	□ Test reports	□ Laboratory reports
□ Operative Reports	□ EKGs	□ Billing information
□ Other		

_____

I understand that this authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.This authorization shall remain valid until written notice is given by me revoking said authorization.

ATTENTION: This is a legal document. By signing, you agree that you understood and accept the terms on this form

- **If the patient is 18 years of age or older**, the patient must sign and date the form.
- **If the patient is 18 years of age or older and incapable of signing**, legally authorized substitute may sign and date the form. Please indicate your legal authority and include documentation of your relationship
  □ Legal Guardian □ Health care agent
- **If the patient is 17 years of age or younger**, the patient's parent or legal guardian must sign and date the form unless exception exists under federal law. Please indicate your relationship:
  □ Parent □ Legal Guardian

Signature *(Required)*	**Date Signed** *(Required) (Month/DD/YYYY)*
Print Name of Person Signing (If not Patient)	
Mailing Address of Patient -Street	

City	State	Zip code	Phone