CARY CARDIOLOGY, P.A.

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

Patient Name: _____ **MRN #:** _____

Date of Birth: _____ **Today's Date:** _____

Daytime Phone: _____

Please indicate the reason for this request: ☐ Continued care ☐ Insurance ☐ Attorney ☐ Personal Use ☐ Other: _____

Information requested:

☐ Discharge summary ☐ History & Physical Examination ☐ Emergency Room Record

☐ Lab Report ☐ X-Ray Report ☐ Operative Report/Procedure Note

☐ Pathology Report ☐ Office Note ☐ Immunization/Vaccination Records

☐ Other: _____

Date of Encounter: _____ ☐ Obtain Rec's From_____☐ Send Rec's To_____

☐ Paper Copy ☐ CD

☐ Pick Up Name of Person to pick up information: _____

☐ Mail Mailing Address: _____

_____

☐ Fax (include area code)_____ ☐Email: _____

I understand that I may cancel or revoke this authorization at any time except to the extent that the information has already been released pursuant to this authorization and before I have revoked my authorization. If I chose to revoke this authorization, I must do so in writing. Unless otherwise revoked, this request will remain in effect for one year and will expire one year after the date signed.

By signing below, I am authorizing Cary Cardiology to obtain any records necessary for continuity of my medical care from any of my medical providers.

Patient/Representative Signature: _____ **Date:** _____

Office Use Only: Medical Records Representative:_____☐ Request initiated Date:_____ ☐ Completed Date:_____

Place Sticker Here

(Rev 08.04.2022)

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