Authorization to Disclose Protected Health Information

The undersigned authorizes

THE HEART CENTER CARDIOLOGY

2375 CHAMPIONS BLVD ● AUBURN, AL 36830

Phone: 334-321-3700 ● Fax: 334-887-7475

to release my health information as noted below:

Patient Information

Patient Full Name: _____ Other Names? _____

Patient Address: _____ **Date of Birth: _____**

City: _____ State: _____ Zip: _____ Phone #: _____

Release Information To

Email address for record delivery: *Please ensure email address is legible!*

You must provide a valid email address, either your own or that of your designated recipient. Your records will be provided as an Adobe PDF file on BACTES Mail Express portal. If you do not retrieve your records within 30 days, they will be deleted. You will receive an email from Bactes.com containing instructions for accessing the records. There may be a fee for collecting your records. If so, an invoice will be provided to you through email.

Name/Facility: _____ Attention: _____

Address: _____ **Phone: _____**

City: _____ State: _____ Zip: _____ **Fax** #: _____

Purpose of Request: ☐ Personal ☐ Treatment ☐ Legal ☐ Insurance ☐ Transfer ☐ Other:_____

Information to be Released

If you fail to specify, a 1 year abstract will be provided.

☐ Please release a **1 year abstract** of my records (includes most recent notes, labs, procedures & testing)

☐ Please release a **2 year abstract** of my records (office notes, labs, procedures & testing, up to 2 years)

☐ **Date Range**: _____:

□ Progress Notes □ Radiology Reports □ Labs

□ Operative Reports □ Injections □ Physical Therapy

□ Other: _____

A valid email must be provided above. If you do not select a delivery method, BACTES will determine the delivery method based on the information provided on this form.* **No charge for records being released to another healthcare provider.

Authorization to Release Protected Health Information

I acknowledge and hereby consent to such, that the released information may contain alcohol, drug abuse, psychiatric, HIV testing, HIV results, or AIDS information. I understand that: I may refuse to sign this authorization and that it is strictly voluntary. My treatment, payment, enrollment or eligibility for benefits may not be conditioned on signing this authorization. I may revoke this authorization at any time in writing, but if I do, it will not have any effect on any actions taken prior to receiving the revocation. **Unless otherwise revoked, this authorization will expire on the following date, event or condition: _____.** *If I do not specify expiration this authorization will expire in 90 days.* If the requestor or receiver is not a health plan or health care provider, the released information may no longer be protected by federal privacy regulations and may be disclosed. I understand that I may see and obtain a copy of the information described on this form, for a reasonable copy fee, if I ask for it. I can request a copy of this form after I sign and date it.

Please confirm that you have filled out this form in its entirety—if form is incomplete, we may be unable to fulfill this request.

Signature*:_____ Date: _____

** For non-emancipated minors under the age of 18, a parent or guardian must sign release form. If patient is unable to sign, a copy of the legal documentation for patient's representative must be supplied with a copy of this form.*