Authorization For Release Of Information

Hunterdon Cardiovascular Associates

Patient's Name (Please Print): _____ DOB: _____

I hereby authorize HUNTERDON CARDIOVASCULAR ASSOCIATES, 1100 Wescott Drive, Suite G-3, Flemington, NJ 08822 (and affiliated locations)

TO DISCLOSE:

❑ My medical records and information pertaining to my medical history, mental or physical condition, services rendered or treatment.

❑ The medical records and information belonging to this patient for whom I have authorization (copy of authorization to be attached) pertaining to his/her medical history, mental or physical condition, services rendered or treatment.

TO:

_____

PHYSICIAN/FACILITY

_____

Street, City, State, Zip Code

The authorization is limited to the following medical records and types of information:

❑ Office visit notes ❑ Cath report ❑ EKG ❑ All medical records ❑ Nuclear cardiac study ❑ Other procedures

❑ Echocardiogram ❑ Insurance information ❑ Blood results ❑ Other

USES:

The person requesting this information may use this information only for the following purposes: _____

_____

DURATION:

This authorization is effective immediately and shall remain in effect until: _____

RESTRICTIONS:

I understand that the requestor of this information may not further use or disclose this information unless another authorization is obtained from me or unless such use or disclosure is specifically required or permitted by law.

ADDITIONAL COPY:

I further understand that I have a right to receive a copy of this authorization upon my request.

Copy requested and received: ❑ Yes ❑ No Initial: _____

X

_____ _____

PATIENT/GUARDIAN, REPRESENTATIVE/SPOUSE**FINANCIALLY RESPONSIBLE** DATE

_____ _____

WITNESS (for Guardian or POA only) DATE

**A spouse or financially responsible party may only authorize release of medical information for use in processing an application for the patient, as a spouse or dependent, for a health insurance plan or policy, a non-profit hospital plan, a health care service, plan or an employee benefit plan.