



**HEART &
VASCULAR**
CLINIC

620 Stanton Christiana Road
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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Facility Releasing Information

The Heart and Vascular Clinic
Medical Records Department
fax# 302-994-9449

Facility Receiving Information

The purpose of this release of information is to provide continuity of my care, for processing an insurance claim or to meet another specific desire of mine. This information may _____, may not _____ include treatment for drug and/or alcohol abuse, psychiatric illness, HIV test results, or AIDS diagnosis, and/or other communicable diseases. I specify that this release is to include:

_____ Office Visit Summary	_____ History and Physical Exam
_____ Laboratory Report	_____ Consultation Report
_____ Radiology Reports	_____ Pathology Reports
_____ Immunization Reports	_____ Others. Specify Below

This authorization specifically pertains to information related to my treatment which occurred on the following dates: _____ to _____.

To assist in identification and location of my records, I am providing the following information.

Name used when treatment occurred: _____

Address given at that time: _____

Date of Birth: _____

SSN# _____

This authorization expires 60 days from the below date, and it covers only treatment prior to that date.

X _____
Patient or person authorized to consent for minor or patient who is unable to sign.

Date _____ Witness _____

NOTICE TO PERSON OR AGENCY RECEIVING INFORMATION: Federal and State Laws and regulations prohibit further disclosure of the information whose confidentiality is protected in the absence of a specific consent of the patient or person authorized to consent for the patient.

118 Sandhill Dr, Middletown, DE 19709 Phone#302-261-8200 Fax# 302-994-9449