



# California Coastal Cardiology, PC

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Board Certified in Cardiovascular Disease

## Authorization for Release of Medical Information

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with the California and Federal Law concerning the privacy of such information. Failure to provide all information may cause a delay in obtaining information needed to provide you with proper care.

Patient Name: \_\_\_\_\_ Date of Birth: \_\_\_\_\_ SSN: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_

### Information to be Released by:

Physician/Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

### Dates of Service to be Released:

From: \_\_\_\_\_ To: \_\_\_\_\_

### Specify Which Records to be Released:

- |  |  |   |
|--|--|---|
| <input type="checkbox"/> Physician Notes   | <input type="checkbox"/> Operative Reports | <input type="checkbox"/> Pathology Reports  |
| <input type="checkbox"/> Lab Results       | <input type="checkbox"/> Radiology Reports | <input type="checkbox"/> History & Physical |
| <input type="checkbox"/> Discharge Summary | <input type="checkbox"/> Entire Record     | <input type="checkbox"/> Other              |

### Records to be Released to:

Physician/Facility Name: \_\_\_\_\_

Address: \_\_\_\_\_ Telephone: \_\_\_\_\_ Fax: \_\_\_\_\_

Signature: \_\_\_\_\_ Date: \_\_\_\_\_

(Patient or Authorized Representative)