CROSS RIVER CARDIOLOGY

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Lenoir, NC 28645

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AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

PATIENT NAME _____

PATIENT ADDRESS _____

CITY/STATE/ZIP _____

DATE OF BIRTH _____

I do hereby authorize _____
NAME AND ADDRESS OF DOCTOR/HOSPITAL

_____
PHONE NUMBER FAX NUMBER

to release my protected health information including medical records to:
Cross River Cardiology, PLLC.

INFORMATION TO RELEASE _____

_____

I understand that medical information may include if applicable:

Alcohol and drug abuse and mental health treatment information protected under regulations in Title 42 of Federal Regulations Part 2.
Information about human immunodeficiency virus - HIV, acquired immunodeficiency syndrome - AIDS, and ARC - AIDS related complex, as defined by Department of Public Health rules (1989 Public Act 174).

I understand that I may revoke this authorization at any time. and that it will remain in effect for a period of 12 months from the date signed. This authorization pertains to fulfillment of the above stated purpose.

I have read the above, and acknowledge that I am familiar with and fully understand the terms and condition of this authorization.

_____
PATIENT OR PARENT SIGNATURE DATE