

Pioneer Valley Cardiology, PC

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Authorization for Release of Medical Records

Patient Name: _____ Date of Birth: _____

Address: _____ Tel: _____

I hereby consent to and authorize _____

Office Address: _____ City/State/Zip: _____

To disclose information from my medical records to:

Name: _____

Address: _____

Specific information I wish to have released includes _____

For the purpose of _____

I understand that I may revoke this consent at any time, except where information has already been released.
This authorization is valid for a sixty (60) day period from the date it is signed, unless revoked.

Signature of patient/empowered representative: _____ Relationship _____

Signature of Witness _____ Date _____

* This medical record may contain information about drug abuse, alcoholism, alcohol abuse, venereal disease, abortion, or mental health treatment. I give consent to release this information.

Signature of patient/empowered representative: _____ Relationship _____

Signature of Witness _____ Date _____

* This medical record may contain information concerning HIV testing and/or AIDS diagnosis or treatment. I give consent to release this information.

Signature of patient/empowered representative: _____ Relationship _____

Signature of Witness _____ Date _____

Prohibition of Disclosure: This information is being disclosed from records when confidentiality is protected by Federal Regulation 42 CFR, Part 2, and cannot be reproduced without written authorization by the patient or his/her empowered representative.

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