JEFFERSON CARDIOLOGY ASSOCIATION
EXPERIENCE, INNOVATION & COMPASSION
SOUTHERN (SOUTH HILLS) PITTSBURGH AREA
Alan Bramowitz, MD | Peter M. Lemis, MD | Michael S. Nathanson, MD | Gennady Geskin, MD

AUTHORIZATION TO RELEASE PATIENT INFORMATION

Patient Name: _____

DOB: _____ SSN_____

1. I authorize _____ to release information to:

   _____.

2. I authorize the following types and dates of health information to be used and or released:
   a. Entire medical record
   b. Discharge summary
   c. History and physical
   d. Laboratory test results
   e. Progress notes
   f. Referral and consultation notes (may list specific doctor)
   g. X-ray results
   h. Other

3. Records are requested for the purpose of: ☐ Continuing Medical Care ☐ Personal Use ☐ Insurance

4. I understand that I have the right to revoke this authorization at any time and that I must put that request in writing and present it to the Privacy Officer or the administrator of this facility who will deliver it to the privacy officer. I understand that the revocation will not apply to the information that has already been released, nor to the in formation that is required by my insurance company.

5. I understand that authorizing the disclosure of this health in formation is voluntary. I can refuse to sign this authorization and my treatment will not be altered. I understand that I may see or copy the information to be used or disclosed. I understand that once my information is disclosed it may not be protected by the same high confidentiality standards as required by HIPPA and enforced by this facility.

I understand that any question that I have concerning this can be answered by calling the facility's Privacy Officer.

_____ _____
Signature of Individual or legal Proxy Date

_____ _____
Proxy Relationship to Individual Date

_____ _____
Signature of Witness Date