Huntsville Cardiovascular Clinic, P.C.

4601 Whitesburg Drive • Suite 201 • Huntsville, AL 35802

Phone: (256) 880-1050 • Fax: (256) 880-7477

William R. Cox, MD, FACC
Kelley W. Smith, MD, FACC
J. Michael Campbell, MD, FACC
William J. Schneider, MD, FACC
Warren L. Strickland, MD, FACC
Jennifer Kiessling, MD, FACC
W. Quinton Foster, MD, FACC, FHRS

Authorization for Release / Request of Protected Health Information

Patient's Name _____ Date of Birth _____

Address _____

SS # (optional) _____ Patient's Phone Number _____

Date of Request _____ Date Needed _____

☐ I authorize Huntsville Cardiovascular Clinic, P.C. **to release information to**:

_____
Name of Provider, Facility or Other

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

OR

☐ I authorize Huntsville Cardiovascular Clinic, P.C. **to obtain information from**:

_____
Name of Provider, Facility or Other

_____
Address

_____
City, State, Zip Code

_____
Phone # / Fax # (include area code)

Purpose For This Request: (Please Check One) ☐ Healthcare ☐ Insurance Coverage ☐ Personal ☐ Other

Type of Records Requested: (Check One or More) ☐ Physician's Orders ☐ Progress Notes ☐ EKG Report

☐ Imaging Results ☐ Echo Report ☐ History & Physical ☐ Stress Test ☐ Hospital Records

☐ Other _____

☐ All Medical Records

AUTHORIZATION VALID FOR THIS REQUEST ONLY

I understand that:

- The information in my health record may include information relating to sexually transmitted diseases, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health services and treatment for alcohol and drug abuse.
- I have a right to revoke this authorization at any time. If I revoke this authorization, I must do so in writing and present my written revocation to the Medical Record Department. The revocation will not apply to information that has already been released in response to this authorization. The revocation will not apply to my insurance company when the law provides my insurer with the right to contest a claim under my policy.
- Once the information is disclosed pursuant to this authorization, it may be re-disclosed by the recipient and the information may not be protected by federal privacy regulations.
- Unless otherwise revoked, the authorization will expire on the following date, event or condition:

  _____

  If I fail to specify an expiration date, event or condition, this authorization will six months from the date of signing.

_____ _____

Signature of patient or legal representative Date

_____ _____

If signed by legal representative, relationship to patient Signature of Witness Date