MEDICAL RECORDS RELEASE AUTHORIZATION

To the patient: Please copy this form and execute a signed original for every physician and hospital having medical records relevant to your medical history.

To:

Doctor / Hospital: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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

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I hereby authorize and request you to release to Dr. Hinchey’s office at the address below, the following medical information:

\_ Complete medical records

\_ Operative Reports

\_ Cardiac data (cath reports, stress, Holter, echo, pacemaker data etc.)

\_\_Pulmonary date (PFTSs, CTPA, Sleep study etc)

\_\_Laboratory Data (over the past year)

\_ Hospital discharge summaries

x All of the above

NOTE:

Dates of interest: \_\_\_\_\_\_\_until \_\_\_\_\_\_\_\_\_OR x All dates

I understand that my express consent is required to release any healthcare information relating to testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders, mental health issues, or drug and alcohol use. If I have been tested, diagnosed or treated for any of the aforementioned issues you are specifically authorized to release all information relating to such issues.

Patient name (please print): \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

SSN: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Date of Birth: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Address \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

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Signature & Date Witness Signature & Date