South Charlotte Cardiology, P.C.

10370 Park Road Suite 102
Charlotte, NC 28210
704.321.2741 phone 704.542.9991 fax

AUTHORIZATION TO RELEASE INFORMATION

PATIENT NAME:_____ **DATE OF BIRTH:**_____

SOCIAL SECURITY NUMBER:_____ **PHONE NUMBER:**_____

SEND INFORMATION TO:

South Charlotte Cardiology, P.C.
10370 Park Road Suite 102
Charlotte, NC 28210
704.321.2741 phone 704.542.9991 fax

SEND INFORMATION FROM:

Name:_____
Address:_____
_____
_____
Phone _____**Fax**_____

INFORMATION TO BE RELEASED:

__Office notes
__EKG
__Stress Test
__Echocardiogram
__Nuclear stress test
__Carotid ultrasound
__Catheterization Report
__Medication List
__Hospital Admission note
__Hospital discharge summary
__Laboratory result
__Other

The practice may disclose my protective health information to the individual(s) below with discussions in my presence and when I am not physically present, including disclosures by telephone, voice mail, fax, e-mail or regular mail. I permit a photocopy or electronic copy of this authorization to be used in place of the original.

The permitted use of the information is to inform the patient.I understand that this consent may be revoked by written notice to South Charlotte Cardiology, P. C. by the patient or representative signing this authorization upon receipt of written notification to ourSouth Charlotte Cardiology. I understand that a revocation is not effective in cases where the information has already been disclosed but will he effective going forward. I understand that information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer he protected by federal or state law. I understand I have the right to inspect or obtain a copy of the protected health information to be used or disclosed as described in this document by written notification to South Charlotte Cardilogy, P.C. I understand my treatment will not be conditioned on signing this authorization. I understand I have the right to refuse to sign this authorization.

X_____ _____ _____
Signature of Patient or Representative — Date — Relationship to Patient

DISCLOSURES REQUIRING SPECIAL CONSENT

My signature below specifically authorizes the release of healthcare information related to the testing, diagnosis or treatment for any of the following conditions:
HIV/AIDS, sexually transmitted diseases mental health/psychiatric disorders, drug/alcohol abuse or treatment.

X_____ _____ _____
Signature of Patient or Representative — Date — Relationship to Patient

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FOR OFFICE USE ONLY
We were unable to obtain a written acknowledgement of receipt of the Notice of Privacy Practices because:
__An emergency existed & a signature was not possible at the time
__A copy was mailed with a request for signature by return mail
__Unable to communicate with the patient for the following reasons:
__The individual refused to sign
__Other:

_____
Prepared by: Signature — Date