

Authorization to Release Health Information

Expires upon one time release

Patient Information:

Name of Patient _____ Date of Birth _____

Address _____

City, State, Zip _____

I authorize the practice below to release my health information:

Please forward/release my health information to:

MECKLENBURG HEART SPECIALISTS, PA

2630 EAST 7TH STREET, SUITE 210

CHARLOTTE, NC 28204

(704) 334-0600 FAX (704) 334-0615

The information below is provided at the request of the patient. (Describe PHI needed)

This authorization shall be in effect until the information has been forwarded as requested.

Patient Information

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to **2630 East 7th Street, Suite 210, Charlotte, NC 28204.**

Signature of Patient or Personal Representative

Date

Description of Personal Representative's Authority (attach necessary documentation)

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