

CARDIOTHORACIC & VASCULAR ASSOCIATES

Authorization to Release Medical Records

(Please read carefully)

Since HIPAA legislation became effective in April of 2003, we are no longer allowed to automatically assume that our patients authorize us to give out information about their care to anyone other than themselves—not even to immediate family members or close friends. For that reason, please list the names of all family members, friends, organizations, etc. that you give us permission to release information to about your care. If anyone not listed on this form calls or otherwise asks us for information about you (even for information as basic as when your next appointment is or how you are doing in surgical follow up), we will have to refuse to give them that information until we get your expressed permission to do so. Please do not list here your primary care doctor, the doctor who referred you to us or your medical insurance(s), as these people automatically have access to your information kept at this office.

The following persons are allowed to have information about my care at CVA.

(Please list all that apply)

(Name) (Relationship) (Phone #)

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(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

(Name) (Relationship) (Phone #)

Patient Name (Print)

Patient or Guardian signature

Date