

**Form 7, AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION**

Tri-City Cardiology Consultants, P.C.

Patient Name \_\_\_\_\_ Patient Date of Birth: \_\_\_\_\_

I give Tri-City Cardiology Consultants, P.C. and staff authority to release medical information regarding my care, to the individuals listed below, if unable to contact me. This authority will be in effect for one (1) year.

NAME	RELATIONSHIP TO PATIENT
_____	_____
_____	_____
_____	_____

Emergency Contact Name \_\_\_\_\_

Emergency Contact Phone Number \_\_\_\_\_

Please Initial below:

- \_\_\_\_\_ No, I only want my medical information released to myself
- \_\_\_\_\_ Yes, I give my permission to leave messages regarding my test results, appointments, etc., at the following phone numbers \_\_\_\_\_
- \_\_\_\_\_ No, do not leave messages regarding my test results, appointments, etc.

Patient Signature \_\_\_\_\_ Date: \_\_\_\_\_

Witness \_\_\_\_\_

• FOR OFFICIAL USE ONLY

We attempted to obtain written acknowledgment of receipt of this **AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION** but could not because:

- \_\_\_\_\_ Individual refused to sign
- \_\_\_\_\_ Communication barrier
- \_\_\_\_\_ Care provided was emergent
- \_\_\_\_\_ Other

Employee Name: \_\_\_\_\_ Date: \_\_\_\_\_