

**FORM 7, AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION
Tri-City Cardiology Consultants, P.C.**

Patient Name _____ Patient Date of Birth _____

1) Please check (✓) one only:

- I only want my medical information released to myself
- I give Tri-City Cardiology Consultants, P.C. and staff authority to release medical information regarding my care. This authority will be in effect for one (1) year.

NAME

RELATIONSHIP TO PATIENT

_____	_____
_____	_____
_____	_____

2) Emergency Contact Name _____
Emergency Contact Phone Number _____

3) Please Initial below:

- _____ 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 _____

ABOVE INFORMATION REMAINED UNCHANGED		
Signed by:	Date:	Witness:
Signed by:	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** _____