

Form 7, AUTHORITY TO RELEASE PRIVATE HEALTH INFORMATION

Tri-City Cardiology Consultants, P.C.

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 unless otherwise updated below.

NAME

RELATIONSHIP TO PATIENT

_____	_____
_____	_____
_____	_____

Emergency Contact Name _____

Emergency Contact Phone Number _____

Initial

_____ 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 Name _____ Patient Date of Birth: _____

Patient Signature _____ Date: _____

Witness _____

Updates _____

• 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: _____