The Chattanooga Heart Institute

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AUTHORIZATION TO RELEASE INFORMATION

Patient Name: _____ Telephone: _____

Address: _____City_____ State____ Zip_____

Date of Birth: _____ Social Security # (last four digits):_____

I authorize the release of information *from*: _____
(Address, phone number, fax)

_____

To: _____
(Address, phone number, fax)

_____

Purpose of Release: _____

Information to be Released *and* Date(s) of Requested Information:
☐ All Records _____ ☐ Office Visits _____ ☐ Other _____
☐ Lab Results _____ ☐ Diagnostic Tests _____
☐ *Hospital*: Procedures, Consultations, Admission & Discharge Summaries _____

This authorization will expire on: _____/_____/_____. (Date may not exceed one year). If not specified, this authorization will expire ninety (90) days from the date signed by the patient or legal authorized representative

I HAVE READ, or had read to me, and understand the above statements. I further understand that I may revoke this authorization at any time, except to the extent that action has already been taken in accord with this authorization. Revocation by the patient or legal representative is allowable only in the event that the release of information has not already occurred.

_____ _____
Signature of Patient or Authorized Legal Representative Date

(If a personal representative of the individual signs the authorization, please print the name of the representative and provide a description of such representative's authority to act on behalf of the individual)

_____ _____
Printed Name of Representative Relationship

_____ _____
Witness Date