Tri-City Pediatric Cardiology, P.C.

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Authorization to Release Protected Health Information

Patient Name: _____ Date of Birth: _____

Patient Address: _____

If release is for family member's records name of patient seen by TCPC: _____

❖ **Release Purpose:**

☐ Continuing care ☐ Other, specify_____

❖ **Release Information**

☐ FROM ☐ TO: TRI-CITY PEDIATRIC CARDIOLOGY, PC

☐ FROM ☐ TO : Specify organization, department, or individual (complete each line below)

_____

Street_____

City_____State _____ ZIP Code: _____

Phone_____Fax_____

This authorization will expire in 1 year from date of signature unless another date is specified: _____

☐ By checking this box, I allow ongoing exchange of information (including future visits) between the above parties until this authorization expires or is revoked.

❖ **Records or Reports to Be Released**

☐ Operative/Procedure notes	☐ Provider notes	☐ Emergency/Urgent care notes	☐ All Records
☐ Laboratory results/Genetic testing	☐ EKG(s)//Echo/Holter/Monitors	☐ Radiology report(s)	
Treatment Years:			

❖ **Signature and Date** The patient or legal representative must sign and date this authorization.

- This authorization may be revoked at any time by providing a written notice of revocation to the Health Information Management Services (HIMS) Release of Information (ROI) department at the facility releasing the information, except to the extent that the Providers have already taken action in reliance on it.
- Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by the Federal Privacy Law (42 CFR Part 2) (HIPAA).
- I may be charged for copies in accordance with state law.
- I may request a copy of the signed authorization.
- I have a right to inspect and receive a copy of the material to be disclosed.

Note: A patient (18 years or older) must authorize the release of their own information unless patient is incapacitated or deceased. If signing for a minor patient, I hereby state that my parental rights have not been revoked by a court of law. Specific situation(s) may require minor's authorization.

Signature (required)	**Date (required)**
Printed Name of Person Signing (if not patient)	
Relationship if Not Patient (legal documentation of the right of access by the signing individual may be required) ☐ Parent ☐ Step Parent ☐ Legal guardian ☐ Foster Parent ☐Other _____	