

AUTHORIZATION FOR RELEASE OF INFORMATION TO HEARTPLACE

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1. I hereby consent to the release and transfer to:		
HeartPlace		
the following information from its records on:		
(Patient's Name)		
Birth Date	Social Security Number	
SPECIFY INFORMATION:		
2. The above information is released for the following purpose		
3. I understand that the specific information to be released a drug or alcohol abuse, mental illness, or communicable di Immune Deficiency Syndrome (AIDS). I authorize the release	sease, including Human Immunodeficiency Virus (H	
4. I understand that I may revoke this Authorization at any effect on any actions HeartPlace too, including any uses of before it received the revocation of this Authorization.		
5. I understand that if my Protected Health Information is privacy protection regulations then such information may be re-		
6. I understand that I have a right to inspect and copy my of with the requirements of the federal regulations found under 4		ed (in accordance
7. I authorize faxing the information to be disclosed to the rec	questing party yes no	
8. I have read and understand this consent and I have signed i	t voluntarily and of my own free will.	
9. This authorization will expire ninety (90) days from the date	te of signature.	
Signature of Patient	Witness	
Specify relationship (legal & authorization where applicable)	Witness	
Date	Date	

Prohibition of Re-disclosure: This information has been disclosed to you from records which are confidential. You are prohibited from making any further disclosure of it without the specific written consent of the person to whom it pertains, or as otherwise permitted by law.