APEX CARDIOLOGY, P.C.

327 Summar Drive •Jackson, TN 38301
Phone: 731-423-8200 • Fax: 731-423-6200

I hereby authorize the release, use, and /or disclosure of my medical records as listed below. I understand that the information enclosed in my records may be subject to rediisclosure by the recipient and no longer protected by federal privacy regulations.

Patients Name: _____

Address: _____

Social Security: _____Date of Birth: _____

I authorize Apex Cardiology, P.C. to:

____release my medical records to: _____

____request / obtain my medical records from: _____

Purpose of request / use: ____ Patient Request ___Continuation of Care

____ Other: _____

Information to be obtained, used, and /or disclosed:

___ Office Records ___Echocardiograms ___Stress Test ___Operative Reports

___ Hospital Procedures (Catheterization, By Pass reports, etc.)

___Itemized Bill ___Other:_____

I understand that the release of my personal medical records may include information concerning my diagnosis and/or treatment for any of the following: drug/alcohol abuse, psychiatric or mental illness, sexually transmitted diseases which include Human Immunodeficiency Virus (HIV) and/or AIDS virus. This authorization will expire 12 months (1 year) from the date provided at the end of this form. I understand that I have the right to refuse to sign this authorization and that my refusal will not result in the physician conditioning the provision of Healthcare with 2 exceptions: 1. Refusal to sign this form, if it is for disclosure of information created for research that includes treatment, may result in the doctor declining to provide the research related treatment. 2. Refusal to sign this form, if it is for disclosure of information created for the sole purpose of disclosure to a third party, may result in the doctor declining to provide the healthcare which is for the sole purpose of creating protected health information for disclosure to third party. I understand that I may revoke this authorization at anytime by notifying the doctor in writing. The revocation will only be effective from the date received and it will not apply retroactively. I understand that this authorization will expire on ____/____/____.

_____ _____
Patient's or Responsible party's Signature Date

_____
Printed Patient Name