Peak Cardiology, P.A.

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1071 Pemberton Hill Rd Ste 102
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Phone: 919-363-6060
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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

Complete all bolded sections

_____ _____/_____/_____
Last Name, First Name, Middle Name **Date of Birth (month/day/year)**

_____
Street address

_____ (_____)_____-_____
City/State/Zip **Best Contact Number**

Select ONE of the following: ____Peak Cardiology to Send Records.
____Peak Cardiology to Request Records.

Date of Service(s):_____

Records needed: ___ All Records ____ Cardiac Testing ____ EKG ____ 2D ECHO/Echocardiogram ____ Stress ECHO

___ Progress Notes ____ Lab Reports ____ ABI ____ Carotid Ultrasound ____ Nuclear Stress

ATTN: YOU MUST FILL OUT THE BELOW SECTION OR WE WILL NOT BE ABLE TO COMPLY WITH YOUR REQUEST

(Please check one) _____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, Psychiatric Care and/or Psychological Assessment, and Treatment for Alcohol and/or Drug Abuse.

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Phone**: (919) 363-6060**
FAX*: **(919-363-6040**

_____
Name/Agency or Facility

_____
Street Address

_____
City, State Zip

Phone**: (_____) _____-_____**
FAX: **(_____) _____-_____**

PURPOSE OF DISCLOSURE:

____ Continuing Care ____ Insurance ____Attorney ____ Self ____ Disability determination
____ Other (please specify): _____

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

_____ _____

Signature of __Individual or __Guardian or __Personal Representative of Patient's Estate **Date**