ACA
ACADEMIC CARDIOLOGY ASSOCIATES, P. C.

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1701 South Blvd East Suite 390, Rochester Hills, MI 48307 (248) 293-0055 Fax (248) 293-3348

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Date:
Patient Name:
Address:
Telephone Number:
Date of Birth:

RELEASE INFORMATION TO ACA

1a) I authorize

_____
NAME AND ADDRESS OF DOCTOR, HOSPITAL Phone number

to release information to:
Academic Cardiology Associates 1701 South Boulevard East Rochester Hills, MI 48307
Fax 248-293-3348

OR

RELEASE INFORMATION TO ANOTHER HEALTH CARE FACILITY

1b) I authorize ACA to disclose information contained in my medical record to:

_____
PHYSICIAN or CLINIC NAME
ADDRESS CITY, STATE ZIP CODE
PHONE NUMBER FAX NUMBER

Specific information to be disclosed:
History and Physical_____
Lab reports_____
Discharge Summary_____
All Cardiac Testing_____
Clinic Records_____
Other_____
All records from last two years _____

(Signature Next Page)

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I understand that medical information may include if applicable: Alcohol and/or drug abuse and/or mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II. Information about Human Immunodeficiency Virus - HIV, acquired immunodeficiency syndrome - AIDS, and AIDS related complex - ARC, as defined by Department of Public Health rules (1989 Public Act 174). Third Party Information. Patient's

I understand that I may revoke this authorization at anytime and that it will remain in effect for a period of 12 months from the date signed. This authorization pertains to fulfillment of the above stated purpose(s). I have read the above, and acknowledge that I am familiar with and fully understand the terms and condition of this authorization.

_____ _____

Patient signature Date