
# ACADEMIC CARDIOLOGY ASSOCIATES

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## Authorization to Release Medical Information

**Patient Name:** _____ **DOB:** _____ **AGE:**_____

**I,** _____**, authorize the release of the following protected health information from:**

**Name of Facility/Physician:** _____

**Address:** _____**City**_____**State**_____**Zip**_____

**Phone:** _____ **Fax:** _____

**To**

**Academic Cardiology Associates**
**1701 South Boulevard East, Suite 390**
**Rochester Hills, MI 48307**
**Phone: 248/293-0055 Fax: 248/293-3348**

_____ **Office Notes** _____ **Lab Results** _____ **Cardiac Cath Records**

_____ **EKG's** _____ **Radiology Reports** _____ **other Cardiac Testing**

_____ **Other:** _____

**I understand that:**

- **By signing this form, I am authorizing the use or disclosure of protected health information as indicated above.**
- **I may refuse to sign this authorization, which will not affect my treatment or payment for health care.**
- **I may revoke this authorization at a time before the information I have requested is released by providing written notice of revocation as specified in the Notice of Privacy Practices.**

- **If the receiving party is not subject to medical records privacy laws, the information may be re-disclosed by the recipient and may no longer be protected by federal or state law. Academic Cardiology Associates shall not be held liable for any consequences resulting from re-disclosure.**
- **If the information to be released contains any information about HIV/AIDS an additional HIPPA release of medical information form will be requested.**
- **Alcohol or substance abuse, mental health or psychiatry notes may have additional compliance requirements that must be met before the information can be released.**
- **A copy of this form will be provided to me.**
- **Academic Cardiology Associates may charge an administrative fee to cover the cost of labor, copying, and postage. Academic Cardiology Associates follows the guidelines found in The Medical Records Access Act, Public Act 47 of 2004, MCL section 333.26269 (the Act). Academic Cardiology will inform me of any charges and arrange for payment.**

_____ _____

**Patient/Representative Signature** **Date**

**If the patient listed is a minor or the patient is unable to sign, then a parent, legal guardian, or personal representative may sign on behalf of this patient. Please sign above and complete the following:**

_____ _____

**Print Name** **Relationship to patient**