



Amish M. Parikh, MD, FACC

**MEDICAL RELEASE FORM**

I. Patient's Name: \_\_\_\_\_ DOB: \_\_\_\_/\_\_\_\_/\_\_\_\_

SSN: \_\_\_\_\_ Phone#: \_\_\_\_\_

II. I hereby authorize Premier Cardiology & Vascular Associates to obtain my Protected Health Information from the following organization(s) and/or person(s).

Doctor or facility name: \_\_\_\_\_

Address: \_\_\_\_\_

Phone#: \_\_\_\_\_ Fax #: \_\_\_\_\_

III. I authorize release of information of the following portions of my medical record:

Mental Health       HIV/AIDS       Substance Abuse       Communicable Disease

Other (specify)       Routine Record Sets: Clinic office visit, lab, radiology, ekg/testing, medicines

IV. Purpose of the Requested Disclosure: Please check one and provide the requested information

At request of the patient \_\_\_\_\_  
Patient's Initials

Other Continuing Care of Patient

I understand that I have a right to revoke this authorization at any time. My revocation must be in writing in a letter provided to the Privacy Officer. I am aware that my revocation is not effective to the extent that the persons I have authorized to use and/or disclose my Protected Health Information have acted in reliance upon this authorization. I understand that I do not have to sign this authorization and that Premier Cardiology & Vascular Associates may not condition treatment on whether I sign this authorization. I further understand that if the person(s) or organization(s) authorized to receive the information is not a health plan or health care provider, the released information may be re-disclosed and would no longer be protected by federal privacy regulations.

I agree that a copy of this release or fax of this release shall be as valid as the original release. If I authorize **Premier Cardiology & Vascular Associates** to fax information, I realize there are inherent risks in faxing Protected Health Information, I understand a fee will be charged to cover the costs of copying, including the cost of supplies and labor of copying and mailing Protected Health Information released to anyone other than another health care provider. I understand I will get a copy of this form after I sign it.

This authorization expires: \_\_\_\_\_  
(Specify date, if less than one year)

\_\_\_\_\_  
Signature of Patient/Authorized Representative      Date

\_\_\_\_\_  
Printed Name of Patient      Relationship to Patient