AUTHORIZATION FOR THE RELEASE OF CONFIDENTIAL INFORMATION TO FAMILY AND/OR FRIENDS

Heartland CARDIOLOGY LLC

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Please print the following information:

Patient: _____ Date of Birth: _____

Address: _____ Phone #: _____
City, State, Zip: _____ Other Name: _____

I hereby authorize Heartland Cardiology to provide my health information to the following individuals for the purposes of coordinating my treatment and care:

Name: _____ Relationship to Patient: _____

Phone #: _____

Name: _____ Relationship to Patient: _____

Phone #: _____

Name: _____ Relationship to Patient: _____

Phone #: _____

Name: _____ Relationship to Patient: _____

Phone #: _____

Name: _____ Relationship to Patient: _____

Phone #: _____

****Do you have a Durable Power of Attorney that governs coordination of medical care/payment? Yes No**
If so, copy of Durable Power of Attorney provided to Heartland Cardiology on _____(date)

I understand that this authorization may be revoked at any time, except to the extent that action has been taken in accordance with this authorization. Unless otherwise specified, this authorization remains in effect until it is revoked. I hereby release Heartland Cardiology and its personnel from all legal responsibility that may arise from the act I have authorized above. Heartland Cardiology is not responsible for completeness, legibility or omission caused by the copying of any medical records from another institution.

_____ _____
Signature of Patient Date Signature of Parent/Legal Guardian Date

_____ _____
Printed Name of Parent/Legal Guardian Relationship

Staff Initials: _____