

## AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name:

DOB:

Address:

Telephone Number:

1) I authorize

NAME AND ADDRESS OF DOCTOR, HOSPITAL

PHONE NUMBER FAX NUMBER EMAIL ADDRESS

to release information to: Boone Health Cardiology  
1605 E. Broadway Suite 300, Columbia, MO 65201

2) I authorize Boone Health Cardiology to disclose information to:

PHYSICIAN NAME CLINIC NAME

ADDRESS CITY, STATE ZIP CODE

PHONE NUMBER FAX NUMBER EMAIL ADDRESS

I understand that medical information may include if applicable: Alcohol and drug abuse and 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. Third Party Information.

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 conditions.

4) Specific information to be disclosed: (include dates)

History and Physical

EKG

Lab reports

Holter/Event Monitor

Discharge Summary

Stress Test

Echocardiogram

OP Notes

Clinic Records

All records from the last two years

X-rays

Other: \_\_\_\_\_

Patient Signature

Date

Witness

Date

Copies needed by

Records copied by