**Authorization To Release/Disclose Protected Health Information**

Date: \_\_\_/\_\_\_/\_\_\_

To: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

Fax: \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_

I, \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_, hereby authorize you to release and disclose the following medical records.

\_\_\_\_\_\_All Medical Records (most common)

\_\_\_\_\_\_Laboratory Reports

\_\_\_\_\_\_Echocardiogram / EKG Reports

\_\_\_\_\_\_Medication Records

\_\_\_\_\_\_Clinical Notes

\_\_\_\_\_\_Surgical Notes

Please send the requested records to the address below:

Elko Cardiology Associates 1784 Browning Way, Suite 1 Elko, NV 89801-8356 (775) 738-5100 – Phone (775) 738-5115 – Fax

**I understand that this disclosure may include information regarding drug and alcohol abuse, psychiatric or mental illness, Acquired Immunodeficiency Syndrome (AIDS) or infection with HIV regulated by Federal Stature (42 CFR Part 2).**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Printed Patient Name Date of Birth**

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

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ Last 4 digits of Soc. Sec. #**

**Signature of patient (or authorized representative)**

**\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_ \_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_\_**

**Date of Signature Relationship**

**Date Authorization will expire: \_\_\_\_\_/\_\_\_\_\_/\_\_\_\_\_**