

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name: _____ Date of Birth: _____

Social Security Number: _____ Other/Maiden Name: _____

I request and authorize **NORTH CASCADE CARDIOLOGY** to release the health care information of the above named patient to: **(Name of Your Primary Health Care Provider)**

Primary Care Physician: _____ Secondary Care MD: _____

Address: _____ Address: _____

City: _____ State: _____ Zip: _____ City: _____ State: _____ Zip: _____

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

THIS REQUEST AND AUTHORIZATION APPLIES TO:

YES NO ALL HEALTH CARE INFORMATION.

YES NO HEALTH CARE INFORMATION RELATING TO THE FOLLOWING CONDITION(S) OR DATE(S) OF TREATMENT: _____

Red Flag Identity: Secret Question: Your first animals name: Pass code: _____

YES NO YOU MAY LEAVE MESSAGES AT MY HOME OR ON MY TELEPHONE OR CELL PHONE REGARDING MY HEALTH CARE AND APPOINTMENT INFORMATION.

YES NO YOU MAY LEAVE APPOINTMENT NOTIFICATIONS VIA ELECTRONIC PHONE MESSAGE.

YES NO YOU MAY SPEAK TO FAMILY MEMBER/S OR FRIENDS REGARDING MY HEALTH CARE.

Family Member or Friend Relationship Contact Number

Family Member or Friend Relationship Contact Number

YES NO I understand that my express consent is required prior to the release of any health care information regarding Testing, diagnosis, and/or treatment for HIV (AIDS virus), sexually transmitted diseases, psychiatric disorders/ Mental health, or drug and/or alcohol use. If I have been tested, diagnosed, or treated for HIV/(AIDS virus), Sexually transmitted diseases, psychiatric disorders/mental health, or drug/alcohol use, you are specifically Authorized to release all health care information relating to such diagnosis, testing, or treatment, legal obligations excluded.

I understand that information disclosed pursuant to this authorization may be re-disclosed to additional parties and no longer protected. I also understand that I may revoke this authorization at any time by signing a revocation form at North Cascade Cardiology and returning it to the Information Privacy/Security Officer. I further understand that any such revocation does not apply to the extent that persons authorized to use or disclose my health information have already acted in reliance on this authorization.

Signature of patient or patient's authorized representative Date Signed: _____

Relationship of person signing if other than the patient _____ Date Signed: _____