AUTHORIZATION FOR RELEASE OF PROTECTED HEALTH INFORMATION (PHI)

☐ 1015 S. Washington
Saginaw, MI 48601
PHONE (989) 754-3000
FAX (989) 754-3002

Michigan CardioVascular Institute

Patient_____
Last First Middle Date of Birth

Address _____
Street City State Zip Code

Telephone Number(_____)_____

I hereby authorize _____

to furnish the most current year's documentation of medical treatment to _____

Additional documentation requested:

_____ Catheterization _____ EP Studies _____ Holter
_____ Angioplasty/Atherectomy _____ Stress/Nuclear _____ Echocardiogram
_____ EKG _____ Operative Report
_____ Other _____

THE INFORMATION IS RELEASED FOR THE FOLLOWING PURPOSE

☐ INSURANCE PAYMENT OR CLAIM ☐ LEGAL MATTER ☐ CONTINUED MEDICAL CARE
☐ OTHER _____

Individually-identifiable health information disclosed pursuant to this authorization may no longer be protected by Federal regulations and may be subject to re-disclosure by the recipient. I hereby release MCVI from all responsibility or liability that may arise from the release or receipt of this information or these records. I authorize and request MCVI to release or obtain (as the case may be) information contained in my patient records, including as applicable: Alcohol and drug abuse and mental health treatment information protected under the regulation in Title 42 of the Code of Federal Regulations Part II, information about communicable diseases, and serious communicable diseases and infections, as defined by Department of Public Health rules (Michigan Public Health Code) which includes venereal disease, tuberculosis, human immunodeficiency virus – HIV, acquired immunodeficiency syndrome – AIDS, and AIDS-related complex – ARC.

This authorization will expire one hundred eighty (180) days after the date below.

I understand that I have the right to withdraw this authorization at any time, except to the extent that action has been taken by my authorization. Such revocation must be in writing and sent to MCVI Medical Records Dept.

SIGNATURE OF PATIENT X		DATE SIGNED
AUTHORIZED PERSONAL REPRESENTATIVE X	DATE SIGNED	**For office use only** Personal Representative Verified_____
SIGNATURE OF WITNESS X		Copy of Verification attached _____

Revised: 3/11/11