PIMA HEART & VASCULAR

Patient Consent to Release Protected Health Information

Authorized by: Patient Legal Guardian/POA _____

The Physician/Practice may use or disclose the following protected health information:

Please check all that apply:

- ☐ All test results
- ☐ The entire medical record
- ☐ Today's chart note only

The following protected health information is specifically exempt from disclosure (may not be shared):

Please check all that apply:

- ☐ All test results
- ☐ The entire medical record
- ☐ Today's chart note only
- ☐ Other: _____

The purpose of the use/disclosure is:

Please circle all that apply:

- ☐ Continued medical care
- ☐ Employer's use
- ☐ Family/spouse's employer's use
- ☐ School use
- ☐ Other: _____

This authorization is in force until:

- ☐ One year
- ☐ It is revoked in writing

Disclosure to:

Spouse: _____

Children: _____

Others: _____

Okay to leave a voicemail at the following phone numbers: _____

_____ _____

Patient's Name (please print) DOB Date

_____ _____

Patient / Guardian Signature Relationship to patient