HEART GROUP
of the Eastern Shore

REQUEST FOR THE RELEASE OF PROTECTED HEALTH INFORMATION

I, _____, date of birth _____/_____/_____
(Printed name of patient)

do hereby consent to and authorize

_____
Name and address of Facility

to disclose to _____, information from my medical records.

The specific type of information to be disclosed includes:

☐ Patient's entire medical record.

Medical Data/Information as related to:

☐ Office Visit
☐ Office History and Physical
☐ Office Consultation Report(s)
☐ Office Radiology Report(s)
☐ Office Laboratory Report(s)
☐ Office Holter Monitor Report(s)
☐ Office EKG
☐ Office Carotid Doppler
☐ Office GXT
☐ Office Blood Pressure Report(s)
☐ Other

The information requested may be faxed to:

☐ **251-990-1921 (Fairhope office)**

☐ (_____) _____ **(Outreach office)**

☐ **or mailed to: Heart Group of the Eastern Shore**
150 S. Ingleside Street
4 Medical Park
Fairhope, AL 36532
Attn: Medical Records

_____ _____
Signature of Patient or Legal Guardian Date