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AUTHORZATION FOR RELEASE OF MEDICAL INFORMATION

Patient's Name: ______________________ DOB: ____________________

I understand the Health Insurance Portability and Accountability Act (HIPAA) allow my health care providers the right to release my protected health information for treatment and payment purposes without my written consent. However, certain state and federal laws require consent from me before specially protected records can be released Therefore, I authorize Mountaineer Cardiology, PLLC. their our medical staff to release my protected health information when requested by any health insurance company/organization in order to process claims filed for office visits, or for benefit assessment. I also authorize the release of my medical information to other hospitals, facilities, physicians; including my primary care physician or referring physicians in order to facilitate my care.

I understand that signing this form permits the release of my complete health records. Including, but not limited to; diagnosis, prognosis, treatment, counseling and or education related to drug/alcohol/tobacco abuse.

I understand that I may revoke this authorization at anytime in writing, except where action has already been taken upon this authorization. My revocation will not be effective until I submit a written request to revoke the authorization to the organization/provider who has been authorized to release my records associated with this authorization.

I have read this authorization or it has been read to me, and I understand the authorization I am granting by signing it. I understand that I have the right to inspect and copy any written information to be disclosed, and the right to properly revoke this authorization at any time. I understand that I have a right to a copy of this form. A copy of this Authorization will be considered the original copy.

This authorization shall be valid for one year from the date of signature, unless properly revoked.

______________________________ ______________________
Signature of Patient or Authorized Rep. Date/Time

______________________________ ______________________
Relationship of Legally Authorized Rep to Patient Date/TIme