GATEWAY CARDIOLOGY, P.C.

RELEASE OF PATIENT INFORMATION AUTHORIZATION FORM

Patient Name: _____ DOB: _____

MEDICAL DATA/INFORMATION REQUEST

	Gateway Cardiology, P.C. 10004 Kennerly Road Suite 185B St. Louis, MO 63128	

_____	Name, address, phone number	_____	Information from physician consults
_____	Social Security Number	_____	Diagnosis
_____	Date of Service	_____	Findings of physical examination
_____	Laboratory data	_____	Reports of diagnostic tests
_____	Reports of surgical procedure	_____	Listing of medications

Other:

Personal Email Address for release of information:_____

We understand that information about you and your health is personal, and we are committed to protecting the privacy of that information. Because of this commitment, we must obtain your written authorization before we may use or disclose your health information for the purposes described below. This form provides that authorization and helps us make sure that you are properly informed of how this information will be used or disclosed.

I understand that I have a right to revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing and send my written revocation to Office Manager of Gateway Cardiology, PC (address listed bellow). I understand that the revocation will not apply to information that has already been released in response to this authorization. I understand that the healthcare provider who is releasing this information to Gateway Cardiology will not condition my treatment, payment, enrollment or eligibility for benefits on weather I sign this authorization.

I understand that authorizing the disclosure of this health information is voluntary. I may refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that the information disclosed may be re-disclosed if the recipient(s) described in this form is not required by law to protect the privacy of the information and the information is no longer protected by health information privacy rules.

Expiration of Authorization: This authorization will expire one year from the date on which it is signed.

Please Initial:

_____ I hereby authorize Dr. _____ to provide **Gateway Cardiology, P.C.** with **all** medical data and information they may request.

Signature of Patient: _____ **Date:** _____