GATEWAY CARDIOLOGY, P.C.

RELEASE OF PATIENT INFORMATION AUTHORIZATION FORM

(This form is required by Gateway Cardiology, P.C. for release of PHI)

Patient Name: _____ **DOB:** _____

Release Information to: _____

Address: _____

Reason for Release: _____

Please Initial:

_____ I hereby authorize Gateway Cardiology to provide the above-named individual or company with **all** medical data and information they may request, concerning my illness or injury.

_____ I hereby authorize Gateway Cardiology to provide the above-named individual or company with **specific elements** of my medical data and information as designated below, concerning my illness or injury.

_____ I hereby **refuse** Gateway Cardiology to provide the above-named individual or company with medical data and information concerning my illness or injury.

MEDICAL DATA/INFORMATION

_____ Name, address, phone number

_____ Social Security Number

_____ Date of Service

_____ Diagnosis

_____ Findings of physical examination

_____ Laboratory data

_____ Reports of diagnostic tests

_____ Reports of surgical procedure

_____ Listing of medications

_____ Listing of treatments

_____ Information from physician consults

_____ Ancillary personnel notes (check all those that apply)

❑ Nursing ❑ Social Services ❑ Pharmacy ❑ Dietary ❑ Psychiatric Services

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

(original to be placed in patient's chart)