

AUTHORIZATION TO INSPECT AND RELEASE PROTECTED HEALTH INFORMATION

PATIENT NAME: _____

BIRTHDATE: _____

ADDRESS: _____

PHONE: (_____) _____

1. I hereby authorize Sweetwater Angiography Center to when medically necessary:

Discloser/release the specified health information:

Receive the specified health information:

TO: _____

FROM: _____

2. The following health information to be disclosed is maintained in the designated record set: (specify the exact information to be disclosed, including dates of service):

Complete Medical Record
(OR the records marked below)

Date of service _____

- Discharge Summary
- History & Physical Examination
- Consultation Reports
- Progress Notes
- Report of Procedure
- Nursing Notes
- OTHER (specify): _____

- Pathology Report
- Heart Diagrams
- Laboratory Tests
- Radiology Reports
- Physicians' Orders

Diagnostic Films/Digital Images (specify): _____

Billing Records (specify): _____

3. For the purpose of: Outcomes Review Quality Control Other

4. I understand that this information may include information relating to specific laboratory tests of HIV infection (Human Immunodeficiency Virus, the causative agents of AIDS) or the diagnosis of Acquired Immune Deficiency Syndrome (AIDS) or AIDS related conditions; treatment for drug or alcohol abuse, mental or behavioral health or psychiatric care, excluding psychotherapy notes.

5. This authorization is given freely with the understanding that:

- a) I may revoke this authorization at any time, except where information has already been released.
- b) The revocation must be in writing and a form is available from the medical record department.
- c) This authorization will expire 180 days from date of signature unless otherwise specified; expires _____.
- d) A photocopy or fax of this authorization is as valid as the original.
- e) Information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and is no longer protected.

Signature of Patient

Signature of Patient's Representative

Date

Representative's Printed Name

Relationship to Patient

Date



SWEETWATER
ANGIOGRAPHY CENTER
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SAC-041 (12/07) (281)240-1016

PATIENT IDENTIFICATION: