IMPERIAL CARDIAC CENTER

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

1. **Authorization**: I authorize disclosure of medical information and health records as described below:
   Name of Patient: _____ Date of Birth: ____/____/____

   Social Security Number: _____ Telephone ( ) _____

2. **Record Holder:** _____
   (Hospital, Medical Group or other Service Provider)

   _____
   Street Address City State Zip

3. Records May Be Released To:

   _____

4. **Type of Information:** This authorization does not apply to the following types of information unless my initial appears beside each applicable Category.

____ Psychiatric Records	_____ Treatment of Alcohol and/or Drug Abuse Treatment
____ HIV Test Results (Human Immunodeficiency Virus)	

____ Discharge Summary	_____ Progress Notes	_____ History/Physical Exam
____ Laboratory Tests	_____ Consultation Reports	_____ Radiology/Nuclear Medicine Reports
____ Operative/Procedure Reports	_____ Billing Information	_____ Emergency Department Reports

____ Still or Video Images and Sound Prepared for Marketing Purposes

____ Other (Please specify) _____

5. **Date(s) of Service:** ____/____/____ - ____/____/____ OR **ALL RECORDS**
   (From) (To)

6. **Use of Information:** The individual or entity identified above is permitted to use my information for the following purposes: **Please MARK all that Apply.**

   _____ Continuing Medical Care _____ Second Opinion _____ Personal _____ Insurance ____ Legal

   _____ Audio/Visual Marketing or Education Media _____ Print Marketing or Educational Media

   _____ Other (Please specify) _____

7. **Duration:** This authorization is valid for one year from the date next to my signature unless otherwise noted here: _____

8. **Signature**: _____ Date/Time: _____
   If signed by other than patient, indicate relationship to patient: _____
   Witness Signature: _____

9. **PLEASE MAIL INFORMATION TO:** _____

   _____

CONFIDENTIAL