SHORE CARDIOLOGY CONSULTANTS

ALI R. MOOSVI, MD. FACP. FACC
TODD S. COHEN, DO. FACC
MICHAEL G. DEVITA, DO. FACC

1640 HWY. 88, SUITE 201
BRICK, NEW JERSEY 08724
TELEPHONE (732) 840-1900
FAX (732) 840-0355
www.shorecardiology.com

AUTHORIZATION TO RELEASE HEALTHCARE INFORMATION

Patient's Name: _____ **Date of Birth:** _____

Previous Name: _____

To: _____

Address: _____

Telephone: _____ **Fax:** _____

I request and authorize _____ to release

healthcare information of the patient named above to:

Shore Cardiology Consultants, LLC
1640 HWY 88 Suite 201 Brick, New Jersey 08724
Telephone: 732-840-1900
Fax: 732-840-0355

This request and authorization applies to:
☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information ☐ Other: _____

I specifically authorize the use and/or disclosure of the follow type of highly confidential information indicated by my initials next to the information type. I understand that this will include information relating to (check if applicable):
☐ AIDS (Acquired Immunodeficiency Syndrome) or HIV (Human Immunodeficiency Virus) Infection
☐ Psychiatric Care ☐ Genetic Information ☐ Communicable Disease(s) ☐ Treatment for alcohol and/or drug abuse ☐ Sexually Transmitted Disease(s)

I authorize the above person/organization and/or members of their staff to furnish the above information, including copies or faxed copies of the information as directed in this authorization. I further agree to release the facility and its employees and agents from all liability that may arise from the release of information here in requested. I understand that authorizing the disclosure of this health information is voluntary. I can refuse to sign this authorization. I need not sign this form in order to assure treatment. I understand that any disclosure of information carries with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.

Patient Signature: _____ **Date Signed**: _____

PROHIBITION ON REDISCLOSURE: This information has been disclosed to you from records that confidentiality of which may be protected by federal and/or state law. If the records are so protected, Federal Regulation (42 CRF Part 2) prohibits you from making further disclosure of this information unless further disclosure is expressly permitted by the written consent of the person to whom it pertains, or as otherwise permitted by 42 CFR Part2. A general authorization for the release of medical or other information is not sufficient for this purpose. The Federal rules restrict any use of the information to criminally investigate or prosecute any alcohol or drug abuse patient.

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Patient's Name: _____ **Date of Birth:** _____

Previous Name: _____

I request and authorize ***Shore Cardiology Consultants, LLC*** to release healthcare information of the patient named above to:

To: _____

Address: _____

Telephone: _____ **Fax:** _____

This request and authorization applies to:

☐ Healthcare information relating to the following treatment, condition, or dates: _____

_____

☐ All healthcare information ☐ Other: _____

Patient Signature: _____ **Date Signed**: _____

ALL REQUESTS WILL BE PROCESSED IN ACCORDANCE WITH APPLICABLE FEDERAL AND STATE LAWS

FEE SCHEDULE: $1.00 per page for first 100 pages

$0.25 a page for remaining pages but not to exceed $200.00 Plus postage

Records in other than paper media: Please inquire with Medical Records for pricing.

Copies will be provided within thirty days of a proper written request.

If records are being faxed there is no charge.

For Office Use Only:

If the patient is a minor, a parent, next of kin or legal guardian must sign the authorization, with the following exceptions and as prohibited by law:

- The minor is pregnant
- The minor is married
- The minor is emancipated (court determined)
- The treatment is a state funded mental health service
- The treatment is for Drug and/or Alcohol Abuse
- The treatment is for Sexually Transmitted Disease
- The treatment is for AIDS or HIV

If patient is deceased, proof or executor or administrator of estate is required, if not applicable surrogate certificate.

Identification Verified via:

☐ Driver's License ☐ Government Issues ID Verified By: _____

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