Khoury Cardiology

Medical Records Release Form

Telephone 803.788.8848 Fax 803.788.4470

Patient Name: _____ Date of birth: _____

Patient Address: _____

Patient Contact Number: _____

I hereby authorize the below entity to release my medical information

Physician/hospital: _____

Address: _____

Phone number: _____ Fax number: _____

To disclose the following protected health information but not limited to, date of service, type of service provided, level of detail, origin or information, etc.

Khoury Cardiology, PA

Leon Khoury Jr., M.D.

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Phone: 803.788.8848

Fax: 803-788.4470

( ) All records

( ) Office notes

( ) Patient demographics

( ) Lab reports

( ) Diagnostic studies

( ) Specific records from _____ To _____

( ) Other _____

This protected health information is being used or disclosed for the purpose of:

_____

This authorization shall be in force and effect until (1) year from the signature date below at which time this authorization to use or disclose this protected health information expires.

I understand I have the right to revoke this authorization in writing at any time by sending such written notification to the health care provider disclosing the information named above. I understand a revocation is not effective to the extent that the provider has relied on the authorization to disclose protected health care information. I understand the named health care provider may not condition treatment and /or payment on whether I provide this authorization. I also understand I have the right to refuse to sign this authorization.

Please sign below to indicate you have read this authorization and agree:

_____

Print Patient Name

_____ Date _____

Patient Signature / Representative