FLOW HEART & VASCULAR

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MEDICAL RECORDS RELEASE FORM

Patient Information:

____
Full Name

____
Date of Birth (MM/DD/YYYY)

____
Address

____
Phone Number

Request Information:

____
Release Information From (Name of Facility or Provider)

____
Address

____
Phone/Fax

Information to Be Released

☐ Complete Medical Record
☐ Continuation of Care

Authorization Expiration

This authorization will expire on ________________________________. If no data is provided. This authorization will expire one year from the date of signature. You may revoke this authorization in writing at any time by contacting the provider above. Revocation will not apply to information already released based on this authorization. Your treatment, payment, enrollment, or eligibility for benefits will not be affected. Information disclosed may be subject to re-disclosure by the recipient and may no longer be protected by HIPAA.

____
Patient/Representative Signature   Date

____
Witness / Staff Signature Date   Date