FLOW HEART & VASCULAR

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MEDICAL RECORDS RELEASE FORM

Patient Information:

_____
Full Name

_____ _____
Date of Birth (MM/DD/YYYY) Phone Number

Request Information From:

_____
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 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 (MM/DD/YY)**