Hillsboro Cardiology, P.C.

Physicians, Board Certified in Cardiovascular Diseases

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MEDICAL RELEASE OF INFORMATION

Patient Name: _____ DOB: _____

Release of medical information to friends/family/caregivers:

☐ Information is not to be released to anyone.

- OR -

☐ I authorize the release of information including appointment date/times, diagnosis, records, and claims information. This information may be released to:

☐ Spouse/partner: _____

☐ Child(ren):_____

☐ Other: _____

This authorization will remain in effect:

☐ From the date of this authorization until the _____ day of _____, 20_____,

- OR -

☐ Until the following event occurs _____.

I understand that by signing this medical release of information form:

- I authorize the use or disclosure of my individually identifiable medical information to the above named individuals.
- I have the right to withdraw permission for the release of my information at any time by sending a written request to Hillsboro Cardiology, P.C.

Signature: _____ Date: _____
(Patient or legal representative)