NAME SEX M F

MR#

AGE / DATE OF BIRTH

ACCOUNT#

(PATIENT PLATE OR PRINT)

MR-109
AEL 9/2005

AUTHORIZATION TO RELEASE/OBTAIN PATIENT INFORMATION

This authorizes Premier Pediatric Cardiology, LLC and it's affiliates to release/obtain information as described below. For a listing of related entities and medical practices, see Premier Pediatric Cardiology's *Notice of Privacy Practices.*

1. **Patient Name (First, Middle, Last):**_____
Address of Patient: _____
City, State, Zip: _____
Telephone Number:_____**Date of Birth:** _____

2. **What is the name of the person or facility that will be releasing your information?**
provide the name, address and telephone number of the person/facility releasing the information.

Name of Person / Facility:_____
Address: _____
City, State, Zip: _____
Telephone Number:_____ Fax Number:_____

3. **What information will be released?** Date of appointment or hospital stay beginning_____ through to _____
____ **Emergency Department** ____ **Home Care** ____ **Outpatient** _____
____ **Inpatient** ____ **Immunization** *(please specify name of department/office)*
____ **Other Information** *(please specify)*_____
If there is any part of the record you do not wish released, please indicate here: _____
If your records contain any information about substance (drug or alcohol) abuse, HIV, or mental health, may this information be released? If yes, please initial next to each type of information to be released:
Drug and/or alcohol treatment or testing _____ **HIV**_____ **Mental Health** _____

4. **What is the name of the person or facility who is to receive your information?**
the name, address and telephone number of the person/facility receiving the information.

Name of Person / Facility: Premier Pediatric Cardiology
Address: 750 Route 73S, Suite 310A
City, State, Zip: Marlton, NJ 08053
Telephone Number: 856-872-2868 Fax Number: 856-872-2876

5. **Please explain why the person or facility above needs this information:**
Patient Care, Cardiology Follow-up

6. **Expiration.** Your permission will expire 90 days after you sign this form unless you indicate otherwise. If you would like to extend your permission for longer than 90 days, please tell us when your permission expires. The date cannot be more than a year from now:_____.

7. **Understanding this Authorization**
- This allows the release or obtaining of information that exists in the patient's medical record when the form is signed, as well as information created after the form is signed until it expires.
- I may withdraw my permission at any time by providing written notice to the above-named provider releasing the information. For information being released by Premier Pediatric Cardiology, see it's *Notice of Privacy Practices* for instructions on how to withdraw (revoke) an authoriztion. If I withdraw my permission, any information that was already released cannot be retrived.
- Information released by Premier Pediatric Cardiology may be released again by the person or organization that receives it and is no longer protected under federal privacy laws. Premier Pediatric Cardiology will protect information it obtains as required by federal privacy laws.
- I understand my permission is voluntary and I/my child will receive treatment whether or not I sign this form.

8. **Signature.** By signing, I understand that I am authorizing Premier Pediatric Cardiology to release/obtain information as described above.

_____ _____ _____
Signature Print Name Date

Relationship to patient: ☐ Patient ☐ Parent ☐ Legal Guardian ☐Other:_____

Information Released by:_____ Date: _____

WHITE – MEDICAL RECORDS YELLOW – PATIENT/PARENT/LEGAL GUARDIAN