AUTHORIZATION FOR RELEASE OF HEALTH INFORMATION

Patient Name _____ **Date of Birth** _____

The above named person must indicate when this authorization is to expire:

- ☐ When information is received
- ☐ In six months
- ☐ On date _____
- ☐ In one year
- ☒ In three years

The person named above is or has been a patient of

Name of Person, Provider, or Facility	Collins Cardiology
Address	1208 Ocilla Rd. Douglas, Ga 31533 / 280 E. Willow Creek Ln. McRae, Ga 31055
Phone	912-384-6276
Fax	912-389-1618

The person named above hereby authorizes Collins Cardiology **to**

Name of Person, Provider, or Facility

- X Request health information from
- X Discuss health information with
- X Send health information to
- X Discuss health information with

The person named above authorizes information to be requested or released by representatives of

Name of Person, Provider, or Facility	Collins Cardiology
Address	1208 Ocilla Rd. Douglas, Ga 31533 / 280 E. Willow Creek Ln. McRae, Ga 31055
Phone	912-384-6276
Fax	912-389-1618

Scope

X All information regarding assessment, diagnosis, and treatment of patient's condition, concern, or disease (specify):

_____

X All information regarding care received by patient between the dates of _____ (Starting Date) and _____ (Ending Date)

X Other information (specify):

_____

Authorization

_____

Printed name of Patient or Authorized Representative

_____ Signature of Patient or Authorized Representative

_____ Date

_____ Signature of witness

_____ Date

If not signed by the patient, indicate relationship of authorizing person to patient:

- ☐ Parent or guardian of minor child
- ☐ Guardian or conservator of conserved patient
- ☐ Beneficiary or personal Representative of a deceased individual