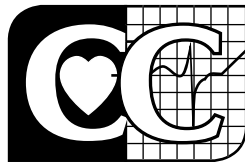


Surender Singh, M.D.
Gordon H. Hutt, M.D.
Stephen T. Bell, M.D.
Nicholas J. Mandalakas, M.D.



**Cardiac
Consultants
P.C.**

Michael G. Lesko, D.O.
Sunil Patel, M.D.
Jerry C. Luck, M.D.
Stephanie Cristoaica, MSN, CRNP

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

****Please read and complete all items****

Patient Name _____ Maiden Name: _____

Date of Birth: _____ Social Security Number: _____ Phone Number: _____

Address: _____

I authorize the use /disclosure of health information about me as described below:

OBTAIN FROM what organization

RELEASE TO what organization

(ADDRESS)

(ADDRESS)

Date(s) of Service: _____

- Complete Medical Record
- Abstract of Hospital Medical Record (History & Physical, Discharge Summary, Consultation Reports
Operative & Procedure Reports, EKGs, Laboratory, X-ray and imaging reports)
- Individual Results Listed Above (please specify): _____
- Immunization Record
- Other (Please specify): _____

Behavioral Health Reports:

- Social History
- Client Data Form
- Admission Evaluation
- Treatment Plan
- Aftercare Instructions
- Psychological Evaluation
- Referral/Treatment Summary
- Notification of Admission
- Other - (Please specify): _____

For the purpose of :

- Further Medical Care
- Changing Physicians
- Personal
- Legal Investigation/Action
- Insurance Eligibility/Benefits
- Other (Please specify): _____

I understand that the information in my health record may include information relating to sexually transmitted disease, acquired immunodeficiency syndrome (AIDS), or human immunodeficiency virus (HIV). It may also include information about behavioral or mental health service, and treatment of alcohol or drug abuse.

State and Federal Law protect the following information. If this information applies to you, Please indicate if you would like this information released/obtained (include dates where appropriate):

Alcohol, Drug, or Substance Abuse Records Yes No Dates: _____
HIV Testing and Results Yes No Dates: _____
Mental Health or Psychotherapy Records Yes No Dates: _____

I understand that I may refuse to sign this authorization and that my refusal to sign will not affect my ability to obtain treatment or payment or my eligibility for benefits. I may inspect or copy any information used/disclosed under this authorization.

I understand that the information disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and no longer protected under the terms of this authorization.

AUTHORIZATION TO USE OR DISCLOSE HEALTH INFORMATION

I understand that I may revoke this authorization in writing at any time. I understand that if I revoke this authorization I must do so in writing (Addressed to Office Manager, Cardiac Consultants) I understand that the revocation will not apply to information that has already been released in response to this authorization.

Signature of Patient or Personal Representative

Date

Name of Patient (Please print)

Cardiac Consultants Witness

Date

IF PATIENT IS UNABLE TO CONSENT OR IS A MINOR COMPLETE THE FOLLOWING

If signed by person other than the patient, state relationship and authority to do so:

- Patient is:** Minor Incompetent Disabled Deceased
- Legal Authority:** Custodial Parent Legal Guardian Executor of Estate of Deceased
 Power of Attorney for Healthcare Authorized Legal Representative

VERBAL AUTHORIZATION

IF PATIENT IS PHYSICALLY UNABLE TO PROVIDE A SIGNATURE AND HAS RECORDS THAT ARE BEING RELEASED PURSUANT TO THE PENNSYLVANIA MENTAL HEALTH PROCEDURES ACT REGULATIONS, COMPLETE THE FOLLOWING.

We the undersigned, do verify that the above Authorization has been read to the client and that s/he has indicated understanding the nature of the Authorization and freely gives his/her verbal consent for the release of the above information

Responsible Person's Signature

Date

Responsible Person's Signature

Date

PLEASE CHECK ONE AND COMPLETE:

- This is an open authorization for release of records to the person or facility noted above.
- My consent for authorization will expire on _____

(717) 299-5000
2112 Harrisburg Pike, Suite 100, P.O. Box 3200, Lancaster, PA 17604-3200
www.cardiacconsultants.net • Fax (717) 299-3510