Foothill Cardiology/California Heart Medical Group, Inc.

Diplomates, American Boards of Internal Medicine, Cardiovascular Diseases

(Patient Release Form)

AUTHORIZATION FOR RELEASE AND / OR DISCLOSURE OF MEDICAL INFORMATION

Completion of this document authorizes the disclosure and/or use of individually identifiable health information, as set forth below, consistent with the Confidentiality of Medical Information Act of 1981, Civil Code Section 56 *et seq,* concerning the privacy of such information.

*****25.00 TRANSFER FEE MUST BE ATTACHED TO THIS AUTHORIZATION IF COMPLETE FILE IS COPIED*****

Please REQUEST Medical Information FROM:

Name of Health Care Provider

FOOTHILL CARDIOLOGY / CA HEART

Medical Office/Hospital

Arcadia ❑
301 W. Huntington Dr.
Suite 301
Arcadia, CA 91007
Tel: 626.254.0074
Fax: 626.254.0079

Covina ❑
315 N. 3rd Ave.
Suite 207
Covina, CA 91723
Tel: 626.915.4700
Fax: 626.214.7814

Pasadena ❑
625 S. Fair Oaks Ave.
Suite 215
Pasadena, CA 91105
Tel: 626.793.4139
Fax: 626.793.4324

Please RELEASE Medical Information TO:

Name of Person or Entity to Receive Information

Street Address

City, State and Zip Code

Telephone # Fax #

SPECIFY RECORDS TO BE RELEASED AND / OR DISCLOSED:

- ❑ All Medical Records from Foothill Cardiology *(from_____ to_____)*
- ❑ Hospital Records *(from_____ to_____)* Hospital Name: _____
- ❑ Laboratory Results
- ❑ Other (specify): _____

I request that the health information release and / or disclosed pursuant to this authorization be used for the following purposes only: _____

Print Patient's Name **Patient's Signature** **Date**

Date of Birth **Social Security Number**

I, hereby authorize FOOTHILL CARDIOLOGY / CALIFORNIA HEART MEDICAL GROUP to obtain and/or disclose the medical information as indicated below to the health care provider, entity, or person I have indicated above.

If signed by someone other than the patient, state relationship and authority to do so.

Representative's Printed Name Representative's Signature Relationship Date

Patient is:

❑ Minor ❑ Incompetent/Incapacitated ❑ Deceased

Legal Authority

❑ Legal Guardian ❑ Parent or Minor ❑ Personal Representative of Deceased

Records Copied By: _____ Date: _____ $25.00 Received Receipt: _____