Peak Cardiology, P.A.
SRIVANI R. AMBATI, M.D., F.A.C.C.
CARDIOLOGY

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

____ ________/________/________
Last Name, First Name, Middle Name Date of Birth (month/day/year)

____ ________-______-__________
Street address Social Security Number

____ (_______)________-__________
City/State/Zip Home phone number

I, ____, do hereby authorize the release of the following medical records:
Patient Name

___ All Records **____ Cardiac Testing** **____ EKG** **____ 2D ECHO/Echocardiogram** **____ Stress ECHO**
___ Progress Notes **____ Lab Reports** **____ ABI** **____ Carotid Ultrasound** **____ Nuclear Stress**

Other:____

ATTN: YOU MUST FILL OUT THE BELOW SECTION OR WE WILL NOT BE ABLE TO COMPLY WITH YOUR REQUEST
(Please check one) _____I do _____I do NOT authorize release of information related to AIDS (Acquired Immunodeficiency syndrome) or HIV (Human Immunodeficiency Virus) Infection, Psychiatric Care and/or Psychological Assessment, and Treatment for Alcohol and/or Drug Abuse.

RELEASE INFORMATION: □ *TO:* or □ *FROM:*	**RELEASE INFORMATION: □ *TO:* or □ *FROM:***
Peak Cardiology, P.A.	______________________________ Name/Agency or Facility
1051 Pemberton Hill Road, Suite 202	______________________________ Street Address
Apex, NC 27502	______________________________ City, State Zip
Phone: **(919) 363-6060**	Phone: (______) _________-______________
FAX*: **(919-363-6040**	**FAX***: (______) _________-______________

* **Peak Cardiology prefers that Medical Records be sent via FAX to the intended recipient. Therefore, to speed the delivery process we would greatly appreciate your effort to verify and provide the correct fax number that the records should be sent.**

PURPOSE OF DISCLOSURE:

____ Referral to Specialist ____ Insurance ____ Workers Comp ____ Change of Doctor/Provider
____ Legal Investigation ____ Disability determination ____ Self ____ Continuing Care
____ Other (please specify): ____

Please provide the <u>best</u> telephone number in the event we need to contact you regarding this form:
(home, work or cell) (______) _______-___________

I hereby authorize disclosure of the health information for the above named patient. This authorization is valid for 12 months from the date of signature. I understand that I may cancel this request with written notification but that it will not effect any information released prior to notification of cancellation. I understand that the information used or disclosed may be subject to re-disclosure by the person or class of persons or facility receiving it and would then no longer be protected by federal regulations. I understand that the medical provider to whom this authorization is furnished may not condition its treatment of me on whether or not I sign the authorization.

____ ________________
Signature of __Individual or __Guardian or __Personal Representative of Patient's Estate **Date**