Southern Cardiovascular Care, PC

1800 Fairview Avenue, Suite 1
Dothan, AL 36301
Phone: 334 699-8900
Fax: 334 699-7498

Medical Information Release

Due to federal privacy guidelines under the Health Insurance Portability and Accountability Act (HIPAA), we are required to have a medical release of information on file for each patient. This authorizes our office to release health information to family members, caregivers, and friends you have designated, about your **HEALTH INFORMATION.** Included would be all health and identifiable information. This authorizes us to share your health information, after proper identification, by verbal or written communication, phone, fax, mail or e-mail as needed for care to only those identified below. Powers of Attorney would be listed separately.

Please list names, date of birth, and phone numbers of the authorized individuals below. Do not list anyone who has not agreed to provide us with their date of birth for identification purposes.

I _____(patient name) give my authorization to the following individual(s) listed below to discuss my medical care with you and/or your staff on my behalf.

Names	**Date of Birth**	**Phone Numbers**
_____	_____	_____
_____	_____	_____
_____	_____	_____

Please list below any health information that you do not want to be given out.

_____

_____

___ **I DO NOT** want you to discuss my medical care with ANY ONE other than myself.

The above information is private and confidential and will be placed in your medical record. This authorization will expire 12 months from the date signed or until we receive written notification from you to revoke it.

Signature _____ Date _____

Witness _____Date_____