



Heart Specialists of Lancaster P.C.

HEART SPECIALISTS OF LANCASTER
802 NEW HOLLAND AVENUE, SUITE 200
LANCASTER, PA 17602
PHONE: 717-291-0700 FAX: 717-291-5786

175 MARTIN AVENUE, SUITE 350
EPHRATA, PA 17522
PHONE: 717-738-0167 FAX: 717-738-0310

RODDY P. CANOSA, D.O.
FRANK W. CORBALLY, D.O.
GREGORY D. COX, D.O.

SCOTT T. RIEBEL, M.D.
TATJANA N. SLJAPIC, M.D.
DANA M. WEINSTEIN, D.O.

Date _____

Dear Patient,

Please complete the *Authorization for Release of Medical Record Information* form by verifying your name spelling, your date of birth, and completing your mailing address and telephone number.

1. List the name and address of the practice or facility you authorize to release information.
2. List the name and address of the entity (practice, facility, other) authorized to receive this information.
3. Describe the information you agree to release.
4. Check the purpose for the release of information.

This authorization will automatically expire at the end of 90 days from the date on this form, unless otherwise indicated.

Complete the form by applying your signature and entering today's date. If a patient representative completes this form, please print the representative's name and list the relationship to the patient.

Thank you for your prompt response. If you have any questions, feel free to contact a member of the Medical Records department at Heart Specialists of Lancaster, P.C.

Sincerely,
Heart Specialists of Lancaster, P.C.

HEART SPECIALISTS OF LANCASTER, P.C.
AUTHORIZATION FOR RELEASE OF MEDICAL RECORD INFORMATION

I HEREBY AUTHORIZE THE RELEASE OF MY HEALTH INFORMATION AS LISTED BELOW:

Patient Name: _____ Date of Birth: _____

Address _____

Telephone: _____

1. **Name and address of Provider or facility authorized to release information**

2. **Person or entity authorized to receive information:**

Address: _____

3. **Description of information:**

Entire Record Other

Specific Dates of Service _____

Special Records: Medical Records to be released *may include* records of drug and alcohol abuse program treatment, mental health treatment, confidential HIV related information or sexual abused/assault counseling records. If records include the above information:

I do want records to be sent **I do not** want records to be sent

4. **Purpose of Release of Information:**

Personal Use Medical Treatment/Management Legal Proceedings

Employment Purposes Insurance Related Other

1. **This authorization will expire:** Date _____ Event: _____ One Year
unless otherwise specified this authorization will expire 90 days after the date of this request.

2. I understand that I may revoke this authorization at any time by notifying the Practice's Privacy Officer in writing at Heart Specialists of Lancaster, P.C., 802 New Holland Ave., Suite 200, Lancaster, PA 17602. I understand that revocation will not have any affect on actions the Practice took before they received the revocation.

3. This authorization is voluntary. I understand that my treatment or payment for services will not be affected if I do not sign this authorization.

4. I understand that if the organization authorized to receive the information is not a health plan or health care provider, the information may no longer be protected by federal privacy regulations.

5. I understand that if the practice is requesting this disclosure, the Practice is not receiving any kind of compensation in exchange for using or disclosing the information described above and that I will be provided with a copy of this form after it has been signed.

Signature of patient or patient's representative Date _____

Printed name of patient's representative _____

Relationship to the patient: _____