CARDIO TERRA, LTD
JERRY J. BOLEY, MD, FACC

OFFICE USE ONLY

PS Account#_____

CONSENT TO RELEASE PERSONAL HEALTH INFORMATION (PHI)

I give permission to release the health information of:

PATIENT NAME:_____DOB:_____

STREET ADDRESS:_____LAST 4 DIGITS OF SSN:_____

CITY, STATE, ZIP_____TELEPHONE: ( )_____

EMAIL ADDRESS_____

Release Information **FROM**:

_____
(Name of Practice/Facility/Person/Physician)

_____
Street Address

_____
City, State & Zip

_____
Phone number Fax Number

Release Information **TO**:

CARDIO TERRA, LTD
(Name of Practice/Facility/Person/Physician)
4112 MONROE RD
Street Address
CELINA, OH 45822-9250
City, State & Zip
567-890-9000 567-890-9009
Phone number Fax Number

Purpose of Release (check reason): X Request of individual/personal _____Continued patient care

____Insurance____Legal purpose including discussions and proceedings ____Other_____

Treatment dates FROM_____TO_____

HOSPITAL SUMMARY: Includes history & physical, discharge summary, operative notes, consults, diagnostic test results, medication list, allergies**. OFFICE/CLINIC SUMMARY:** May include most recent office visits, physical exam, consults, and diagnostic test results.

HOSPITAL (check all that apply)

- ○ Hospital Summary
- ☑ Discharge Summary
- ○ H&P
- ○ Operative Report
- ☑ Lab Report
- ☑ Radiology/X-Ray Report
- ○ Pathology Report
- ☑ Cardiac Reports/EKG

Other_____

OFFICE/CLINIC (check all that apply)

- ☑ Office/Clinic Summary
- ☑ Office Visits
- ☑ Physical Exam
- ☑ Consult Report
- ☑ Lab Report
- ☑ Radiology/X-Ray Report
- ☑ Cardiac Reports/EKG

Other_____

PATIENT'S RIGHTS-I understand that:

- **I can cancel this permission at any time. I must cancel in writing and send or deliver cancellation to releasing facility or practice named above. Any cancellation will apply only to information not yet released by facility or practice.**
- **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 services and treatment for alcohol and drug abuse.**
- **I can refuse to sign this authorization. I need not sign this in order to assure treatment.**
- **Any disclosure of information carried with it the potential for an unauthorized redisclosure and the information may not be protected by federal confidentiality rules.**

This permission expires one year after the date of my signature unless another date or event is written here:_____

SIGNATURE:_____

PRINT NAME:_____

DATE:_____

If the patient lacks legal capacity or is unable to sign, an authorized personal representative may sign this form.

- ◯ HEALTHCARE AGENT/POA
- ◯ ADULT CHILD
- ◯ EXECUTOR/ADMINSTRATOR/ATTORNEY OF FACT
- ◯ SPOUSE
- ◯ AFFIDAVIT NEXT OF KIN
- ◯ OTHER