Garrett Rogers, MD, FACC
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Office: (910) 353-3000 Fax: (910) 238-4456

AUTHORIZATION TO RELEASE MEDICAL INFORMATION

PATIENT: (PLEASE PRINT)

____

LAST NAME FIRST NAME MI DATE OF BIRTH

____

ADDRESS CITY STATE ZIP PHONE NO.

RELEASING: (NAME OF INDIVIDUAL OR AGENCY RELEASING INFORMATION) PHONE NO. FAX NO.

I AUTHORIZE: ______________________________________ ( ) ____________ ( ) ____________

____ TO RELEASE MY MEDICAL RECORDS

ADDRESS CITY STATE ZIP

(CHECK APPROPRIATE BOX)

DATE OF SERVICES INCLUDE: ______/______/______ TO ______/______/______

- ☐ OFFICE NOTES
- ☐ MEDICATION LIST
- ☐ HISTORY AND PHYSICAL
- ☐ HOSPITAL ADMISSION SUMMARY
- ☐ HOSPITAL DISCHARGE SUMMARY
- ☐ CABG / STENT / CATH REPORT
- ☐ STRESS TEST REPORT
- ☐ EKG REPORT
- ☐ ECHO REPORT
- ☐ LABS
- ☐ XRAY (CHEST)
- ☐ OTHER______________________________

RECEIVING: (NAME OF INDIVIDUAL OR AGENCY RECEIVING INFORMATION) PHONE NO. FAX NO.

DR GARRETT ROGERS / SEACOAST CARDIOLOGY CONSULTANTS, PLLC **(910) 353-3000** **(910) 238-4456**

I understand the information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may be subject to redisclosure by the recipient and mayno longer be protected by federal or state law.

I understand that I may revoke this release of information at anytime through a written intent to cancel. I also understand that there may be information in these records that I may not want to be released. The following information should NOT be released, even if occurring during these dates:

____

I understand that all other information, such as HIV testing or treatment of AIDS or AIDS related conditions, any drug or alcohol abuse, drug-related conditions, alcoholism, and/or psychiatric/psychological conditions may be released to the above mentioned entity.

____ ____________________

SIGNATURE OF PATIENT, PARENT, GUARDIAN, CONSERVATOR OR PATIENT'S REPRESENTATIVE DATE

____ ____________________

WITNESS DATE