Cardiology Wellness Center

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2400 Patterson Street, Suite 218 **Nashville, Tennessee 37203**
Email: cardiowellness@bellsouth.net Phone: (615) 884-4425
URL: www.cardiologywellness.net Fax: (615) 891-7961

Patient Authorization to Share Medical Records

or Disclose Other Protected Health Information to Cardiology Wellness Center

To: _____
Name of Doctor, Healthcare Provider, or Hospital

Contact Information of Healthcare Giver and/or Health Facility:
Address: _____
_____
_____
_____

Fax Number: _____
Phone Number: _____
Email Address: _____

I hereby authorize and request you or your agent to release my:

- ☐ Complete Medical Records
- ☐ Medical Records for the period on or about: _____
- ☐ Other records (please specify)_____:

And send via mail or fax to:

Cardiology Wellness Center
2400 Patterson Street, Suite 218
Nashville, Tennessee 37203
Phone: (615) 884-4425
Fax: (615) 891-7961

I understand that when the information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I understand I do not have to sign this authorization in order to get health care benefits. I understand that I have the right to revoke this authorization at any time in writing, except to the extent that the medical provider named above or Cardiology Wellness Center has acted in reliance upon the authorization.

Patient: _____
Date of Birth: _____
Social Security Number: _____

Signature: _____
Date: _____