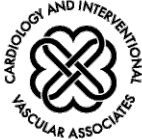

CIVA
THE CARDIOVASCULAR SPECIALISTS

Jack Spitzberg MD
Charles Levin MD
Martin Berk MD
Tony Das MD
James Park MD
Kenneth Saland MD
Brian Lé MD
Tulika Jain MD

AUTHORIZATION FOR RELEASE OF PATIENT INFORMATION

Patient Name : ____

Social Security Number: ______________________________

Patient Number: ______________________________

Date of Birth: ______________________________

PATIENT INFORMATION IS NEEDED FOR:

____ Continuing Medical Care ____ Personal Use
____ Other____

INFORMATION TO BE RELEASED OR ACCESSED:

____ History and Physical ____ Operative Report ____ Radiology Report
____ Entire Chart ____ Radiology Films ____ Test Results
____ Consultations ____ Labs ____ Billing
____ Other_____________________________________

I hereby authorize the release of information

From ____
Physician's Name

I hereby authorize the release of information

To ____
Doctor, Attorney, Hospital, Insurance, Etc.

____
Address Phone or Fax

I understand that if I am requesting my **Radiology Films,** I will be charged a fee of $8.00 per sheet for a copy; the original films are owned by CIVA.

I understand there will be a fee for copying and releasing my medical records, and that such fee is in accordance with state and federal guidelines.

I understand that my records are protected under state and federal law. I understand that specific information to be disclosed may include history of drug or alcohol abuse, mental health treatment, Aids, or any other medical information.

Signature: ___________________________________ Date: ____________________
Patient or Legally Authorized Representative

Print Name: ______________________________ **PLEASE FAX TO 214.369.6042**