PRINCE WILLIAM CARDIOLOGY ASSOCIATES

I hereby authorize ____
(telephone # ____________________ / fax #____________________) to release my health information as described below. I understand that this authorization is voluntary. I understand that the released information may be subject to re-disclosure and no longer protected by privacy laws. You may disclose this health information to:

Prince William Cardiology Associates
8569-B Sudley Road
Manassas, VA 20110
(703) 369-5959 (telephone)   (703) 369-7473 (fax)

You may disclose the following health information (check all that apply):
______My entire record.
______My health information related to the following treatment or condition:
____
____
______My health information for the following date(s): ____________________________
____
______Other (specify): ____

Reason for this authorization (check all that apply):
______At my request
______Other (specify): ____

My Rights:
I understand that my health care and the payment for my health care will not be affected if I do not sign this form. I understand that I may see and copy the information described on this form if requested and I may request a copy of this form after I sign it. I understand that this authorization is valid for one year after the date of my signature. I also understand that this authorization can be revoked by notifying ______________________________________ in writing, but if I do, it will not
(Name of doctor/practice/group)
affect any actions already taken based upon this authorization.

Patient Name: ____

SSN: ____________________________________ Date of Birth: __________________________

Address: ____

Telephone: ______________________________ Date of Request: ________________________

X ____
Signature of patient/guardian Relationship to patient

Date faxed/mailed: ________________________ Date received: __________________________