Southern Cardiovascular Associates, P.C.
1102 Goodyear Avenue
Gadsden, AL 35903-1109

Release of Health Information

Date_____

_____I hereby authorize Southern Cardiovascular Associates, P.C. (SCA), its agents, employees and contractors, to release and disclose all or any part of my medical records to and discuss any aspect of my medical care with:

Name of family member or friend	Phone
_____	_____
_____	_____
_____	_____
_____	_____

_____Please do not discuss my medical records or any aspect of my medical treatment with anyone other than me other than as outlined below.

I hereby authorize the release and disclosure of any and all of my medical records to any other individual or entity, including, but not limited to, any referring physician, hospital, or other health care provider, which, in the opinion of the staff or the physicians of SCA, may be of assistance in providing or continuing my medical care and treatment or for assisting in any reimbursement or benefits.

This authorization shall expire on _____, or at the latest, one (1) year from the date indicated above. I understand I may revoke this authorization at any time, in writing, unless SCA has relied on this authorization.

I understand that information disclosed pursuant to this release may be re-disclosed by the authorized recipient and no longer protected by the privacy rules of the Health Information Portability and Accountability Act of 1996.

I acknowledge that I have been provided with the Notice of Privacy Practices of Southern Cardiovascular Associates, P.C., to review, and informed that I may keep a copy for reference or obtain a copy upon request.

_____ _____
Patient Witness

If the patient is a minor or unable to sign, then complete the following:

Patient is a minor or is unable to sign because_____.

_____ _____
Person and Relationship Witness