

NEWPORT COAST CARDIOLOGY
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Authorization for release of Medical Records

Patient Name: _____

DOB: _____

Phone: _____

Fax: _____

I request and authorize the release of my information and medical records concerning my history, treatment, examinations and/or hospitalizations to:

Name: _____

Address: _____

Phone: _____ **Fax:** _____

I understand that this form does NOT authorize the release of any medical information concerning HIV test results and/or treatments, sexually transmitted diseases, psychiatric care, psychological assessment and/or treatment, drug or alcohol abuse treatment or pregnancy termination.

I understand that the release or transfer of the information specified above to any person or entity not specified is prohibited.

Signature of Patient

Date

Signature of patient's Legal Representative (if applicable)

Legal Representative's relationship to patient