Ronald J. Bloom, MD, FACC
Brett Nowlan, MD, FACC, RPVI, ABCL
Patrick J. Corcoran, MD, FACC, FSCAI, RPVI
Carolyn M. Kosack, MD, FACC
Tracy Patel, MD, FACC, RPVI
Maria Theresa Santos, MD, FACC, RPVI

Cottage Grove Cardiology, P.C.
Specializing in Cardiovascular Medicine

Julian Esteban, MD, MS, FACC
Jawad Haider, MD, FACC
Vincent F. Romano, MD, FACC
Aileen Ingal, MD, FACC, RPVI
Erin Vincent, PA-C
Jason Cornelio, PA-C

Medical Records Release/Request Form

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) states the Practice cannot share your Protected Health Information (PHI) without your permission, except in certain situations. For example your PHI can be shared without your permission if it is used to facilitate your healthcare treatment, payment, or for healthcare operations. **By signing this form, you are giving us permission to share your PHI as you indicate below.**

PATIENT INFORMATION

Patient Full Name: _____ Other Names During Treatment? _____
Patient Address: _____ Date of Birth: _____
City: _____ State: _____ Zip Code: _____ Phone #: _____

RELEASE INFORMATION TO

Name/Facility: _____ Attention: _____
Address: _____ Phone #: _____
City: _____ State: _____ Zip Code: _____ Fax #: _____
Purpose of Request: □ Personal □ Treatment □Legal □ Disability
□ Transfer/Reason _____ □ Other: _____

Connecticut state law permits us to charge $.65 per page. This fee is all inclusive of labor and copying. Postage is additional. There is no charge for Veteran's. Unless otherwise specified, only the most recent findings, progress notes and test results will be provided.

INFORMATION TO BE RELEASED

□ Please provide my entire medical record
□ Please provide my medical record for dates: From: _____ To: _____
This authorization is valid for 1 year unless dates are specified: Effective: _____ through _____
I understand the recipient of this information may not use or disclose this information except for the expressed purposes identified above; or such use or disclosure is specifically required or permitted by law.

SIGNATURE

Signature: _____ Print Name: _____ Date: _____
If this form is completed by someone other than patient, please print name, address, and initial below to indicate relationship.
Name: _____ Address: _____
Guardian: ____ Conservator: ____ Parent: ____ Patient's Representative ____
I understand I have a right to receive a copy of this authorization.
A copy of a legal document such as POA or Health Surrogate must be submitted if we do not already have one on file.

Refusal to sign Authorization: I understand that:
• By declining to sign this form my medical treatment and insurance benefits will not be affected, however my medical records CANNOT be released.
• I may revoke this authorization at any time by notifying this medical practice in writing as described in the Notice of Privacy Practices. My revocation will not affect actions taken prior to its receipt.
•If the recipient of my information is not a health care provider/health plan covered by HIPAA, the information may be re-disclosed by the recipient and no longer protected by HIPAA.

ALL INFORMATION MUST BE COMPLETE IN ORDER FOR REQUEST TO BE PROCESSED
We have 30 days from the date of receipt to process medical record request.

REVOCATION SECTION

I hereby revoke this authorization, effective _____/_____/_____.

_____ _____
Patient Signature Date

_____ _____
Printed Name of Patient Birthdate

_____ _____
Signature of Practice Privacy Officer Date

If the practice is seeking this authorization from you for a use or disclosure of you PHI, we will provide you with a copy of this signed authorization.