



**Miami
Cardiology
Group**

Excellence in Cardiovascular Care

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AUTHORIZATION FOR RELEASE OF MEDICAL RECORDS

PATIENT NAME: _____

SS#: _____ Date of Birth: _____

I hereby authorize _____, Medical Records Department, to release my medical records to:

NAME: _____

ADDRESS: _____

STATE/ZIP: _____

This authorization is for the listed date(s) of treatment: _____

Please specify portion(s) of medical records requested: _____

By authorizing the release of the above mentioned records, I understand that the medical records are confidential and can not be disclosed without specific written consent of the person to whom they pertain, or as permitted by law. I further understand that once released, the record custodian, or its employees have no responsibility or liability that may arise regarding any aspect of this authorization.

I also understand that I may revoke this consent in writing at any time, except where disclosure has already been made or upon occurrence of the purpose for which this disclosure is authorized.

This authorization for release of information (unless expressly revoked earlier) expires six (6) months from the date the release was last signed by the patient or authorized agent.

 PATIENT SIGNATURE/DATE

 WITNESS SIGNATURE/DATE

Revised 04/03/2003

