Morris Cardiovascular & Risk Reduction Center

PERMISSION TO RELEASE MEDICAL INFORMATION

Patient Name: _____

Date of Birth: _____ SSN: _____

I hereby authorize the release of information concerning my medical history and/or treatment to/from the persons listed below:

☐ Entire Medical Record
☐ Partial Medical Record ☐ **To** ☐ **From**

Dr. Clifford Morris, MD - Cardiologist
228 Johnson Creek Drive
Chester, VA 23836
Phone: (804) 530 - 1044
Fax: (877) 718 – 0972

☐ Entire Medical Record
☐ Partial Medical Record ☐ **To** ☐ **From**

_____

_____

_____

Phone: _____

Fax: _____

Please note, per federal regulation §164.506, a covered medical entity may use or disclose protected health information for treatment, payment, or health care operations.

I understand I have the right to revoke this authorization by providing a written request to do so to the above-named physician or office. I understand that the revocation will not apply to information that has already been released. Unless otherwise revoked, this authorization will expire 12 months from the date signed. I understand that authorizing the disclosure of this health information is voluntary. I understand that any disclosure of information that carries with it the potential for an un-authorized re-disclosure and the information may not be protected by confidentiality rules.

NOTE: There is a charge for all copies of records for personal, legal, or insurance purposes.

_____ _____

Patient Name, Printed *Date*

_____ _____

Signature of Patient or Responsible Party *Relationship to Patient, if applicable*