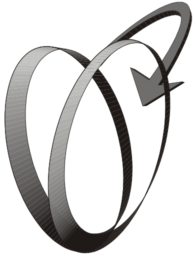

NORTH SHORE CARDIOLOGY CONSULTANTS

BOARD CERTIFIED CARDIOLOGISTS

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Authorization for NSCC to Release Confidential Health Information

I,____, hereby authorize ***North Shore Cardiology Consultants*** to release to: (Print Patient Name or Patient Representative)

____
(Name of Health Care Facility, Physician, Agency, or Self etc.)

____
(Street Address, City, State and Zip Code)

the following information contained in the patient record of ____
(Patient's Name)

born________________, residing at____:
(Birth date) (Street Address, City, State and Zip Code)

The following information may be released:

☐ Laboratory Reports	☐ Treadmill Tests	☐ Nuclear Stress Tests
☐ Radiology Reports	☐ Stress Echocardiograms	☐ Holter Monitors/Event Recorders
☐ Pathology Reports	☐ Echocardiograms	☐ Carotid Ultrasounds
☐ Progress Notes	☐ Medication Records	☐ EKG's
☐ Vascular Studies	☐ ALL RECORDS	

☐ Other: ____

- I understand that Federal Regulations may protect my medical records, including any alcohol or drug abuse data. I authorize release of my records including any information regarding genetic testing (Genetic Information Nondiscrimination Act of 2008, also referred to as GINA), drug and alcohol abuse.
- Information concerning mental illness, HIV, Aids, and HIV related illness and sexually transmitted or other serious communicable diseases may be controlled by various state or federal laws and regulation.
- I consent to the release of such information as pertains to my healthcare.
- I understand that information used or disclosed pursuant to this authorization may be subject to re-disclosure by the recipient and may no longer be protected by law.
- I understand that this authorization is valid until it expires, unless revoked before that.
- I understand that I may revoke this authorization at any time by giving written notice to the physician of my desire to do so. I also understand that I will not be able to revoke this authorization in cases where the physician has already relied on it to use or disclose my health information. Written revocation must be sent to the physician's office. Absent of such written revocation, will terminate this Authorization for Release of Confidential Health Information one month from the date signed.
- I am aware that there may a fee associated for copying records based on the State of Illinois Comptroller guidelines.

____ ____________________
Name of Patient (Please Print) Date of Birth

____ ____________________
Signature of Patient Date

____ ____________________
Signature of Patient Representative if Patient is Unable to Sign Date

__________________________ ______________________________________
Name of Representative (Please Print) Relationship of Patient Representative to the Patient (Please Print)

____
Reason the Patient is Unable to Sign (Please Print)

RE-DISCLOSURE: Notice is hereby given to the patient or legal representative signing this Authorization that ***North Shore Cardiology Consultants (NSCC)*** cannot guarantee that the Recipient receiving the requested health information will not re- disclose any or all or it to others. Notice is hereby given to the Recipient that law prohibits the re-disclosure of any health information regarding drug and/or alcohol abuse, HIV and mental health treatment.