AUTHORIZATION FOR RELEASE OF INFORMATION

I, _____, hereby authorize _____to disclose

the following protected health information to:

CARDIAC CARE GROUP, LLC

South Cape Business Center
3208 Chiquita Blvd. S, Suite 110
Cape Coral, FL 33914
Tel: 239.574.8463
Fax: 239.574.8491

Specifically describe the information to be disclosed, including, but not limited to , meaningful descriptors such as date of service, type of service provided, level of detail to be released, origin of information, etc…

_____

_____

This protected health information is being used or disclosed to carry out treatment, payment and/or health care operations of Cardiac Care Group, LLC, for the purpose of continuity of care

This authorization shall be in force and effect until _____
Date or event that relates to the purpose of the disclosure

at which time this authorization to use or disclose this protected health information expire. I understand that I have the right to revoke this authorization, in writing, at any time by sending such written notification to the Office Manager of Cardiac Care Group, LLC, at 3208 Chiquita Blvd. S, Suite 110, Cape Coral, FL 33914. I understand that a revocation is not effective to the extent that Cardiac Care Group, LLC has relied on the use or disclosure of the protected health information. I understand that information used or disclosed pursuant to this authorization may be subject to additional disclosure by the recipient and may no longer be protected by federal or state law. Cardiac Care Group, LLC, will not condition my treatment, payment, enrollment, (if applicable) in a health plan or eligibility for benefits on whether I provide authorization for the requested use or disclosure. I understand that I have the right to refuse to sign this authorization.

_____ _____

Signature Date of Birth

_____ _____

Print Date

_____ _____

Social Security # Signature of Witness