LGH MERRIMACK VALLEY CARDIOLOGY ASSOCIATES, LLC

Robert M Shulman, MD FACC · Jose M. Carrion, MD FACC · Richard G. Birkhead, MD FACC · James B. Waters, MD FACC
Harsh C. Sanchorawala, MD FACC · Walter M. Jo, MD FACC · Eric J. Ewald, MD FACC · Omar A. Ali, MD FACC
Kirk J. MacNaught, MD FACC · Arash Tabaee, MD FACC · Benjamin Smith, MD FACC · Christopher D. Hong, MD FACC

Patient Authorization For Release of Protected Health Information

PLEASE FAX TO (978) 250-8189

Date: _____ Name (please print): _____ DOB: _____

Address: _____

I, _____, hereby authorize release of my protected health information (information contained in my medical record) to the following entity:

LGH Merrimack Valley Cardiology Associates, Inc.
Attn: Medical Records
14 Research Place, North Chelmsford, MA 01863
Phone: (978) 256-6607 · Fax: (978) 250-8189

Description of Information to be Disclosed: **ANY OF THE FOLLOWING RECORDS**

1. Most Recent Office Visit Note
2. Recent Blood Lab Results/Prior EKG
3. Prior Cardiac Testing: CT, MRI Echocardiograms, ETT Stress Tests/Nuclear Imaging, Cardiac Monitor Reports, etc.
4. Hospital (Cardiology) Consults, History/Physical Reports, Cardiac Procedure Reports/Discharge Summaries

Patient/Legal Guardian Signature: _____

If authorized individual, relationship to patient: _____

HIPAA – Notice of Privacy

I acknowledge having received a copy of the practice's Notice of Privacy Practices.

Patient / Guardian Signature: _____

Patient Financial Responsibility

Your signature on this form indicates that you are responsible for all fees and charges for services you receive that are not covered under your health plan. Please remember that it is your responsibility to confirm with your health plan whether the services provided to you will be covered by your insurance.

Patient / Guardian Signature: _____
