R. Alberto Rosa, MD, FACC
Kenneth P. Sunnergren, MD, FACC
G. Robert Myers, MD, FACC
Ajith Kumar, MD
Penny F. Johnson, DNP, CRNP
Samantha Eckrote, FNP

Patient ID:____________________
Date: ________________________

Medical Records Release

☐ Records to request from: ____

(Include correct spelling, phone and fax number)

☐ Records to be sent to: ____

(Include correct spelling, phone and fax number)

I hereby authorize you to use or disclose the specific information described below, only for the Purpose and parties also described below:

☐ Medical Records only

☐ Include mental health records

☐ Include drug and alcohol records

☐ Include STD records

☐ Include HIV records

☐ Include genetic information records

Entity requesting the information and authorized to make the requested use:

Cardiovascular Consultants of Southern Delaware

16704 Kings Highway, Lewes, DE 19958, FAX (302) 703 6645 ***or*** (302) 645 1228

This information is being requested for the following purpose(s):

☐ Medical Treatment ☐ Legal Proceeding ☐ Insurance Purposes ☐ Other: __________________

This authorization shall remain in effect from the date signed below until: ________________________

(*Expiration date/event*)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above,
  Attention: Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer is protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research/ related treatment, in which case you may refuse to provide that research-related treatment)
- I acknowledge that I have received the "Notice of Privacy Practice" and authorize **CVCDE** to Release or obtain my private information for the purposes of my treatment, to obtain payment from a third party or conduct normal healthcare operations, per the Health Insurance Portability and Accountability Act of 1996.

Cardiology
Lewes Office:
16704 Kings Highway
Lewes, De 19958-4929
(302) 645 1233 phone
(302) 645 1228 fax
Millville Office:
35141 Atlantic Avenue
Unit 3
Millville, De 19970-6954
(302) 645 1233 phone
(302) 645 1228 fax

PRINTED Patient Name: ____

Signature: ____

Last four digits of Social Security: ___________________________ Date of Birth: _____________________________

If signed by personal representative, please include printed name and relationship: _________________________________