Aamer A. Qureshi MD, FACC, FSCAI
Stephanie Baumann PA-C

2711 Randolph Rd. Suite 305
Charlotte, NC 28207
Phone: (704) 334-0600
Fax: (704) 334-0615

Authorization for Release of Information

Name of Patient:_____ Date of Birth:_____

MECKLENBURG HEART SPECIALISTS is authorized to release protected health information about the above named in the following manner and to the identified persons listed below.

List each person/entity to receive information and verify the type of information to be released.

May we leave you a message?
☐ Yes ☐ No
Phone Number(s):_____
_____

May we leave results of your tests on your voicemail? ☐ Yes ☐ No

May we leave appointment reminders on your voicemail? ☐ Yes ☐ No

1. Other Person ☐ **Financial** ☐ **Medical**
Name:_____
Relationship to Patient: _____
Phone Number:_____

2. Other Person ☐ **Financial** ☐ **Medical**
Name:_____
Relationship to Patient: _____
Phone Number:_____

Email Communication – Provide Email Address:
_____

☐ Financial ☐ Appointment Reminders
☐ Medical ☐ Breach Notification

☐For email communication: I understand that if information is not sent in an encrypted manner, there is a risk it could be accessed inappropriately. I still elect to receive email communication.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law
- I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing.

This authorization will be in effect until revoked by the patient.

_____ Date: _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (Attach necessary documentation)

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Authorization to Release Health Information

Patient Information:

Name of Patient: _____ Date of Birth: _____

Address: _____

City, State, Zip: _____ Phone: _____

I authorize the practice below to forward/release my health information:

- Primary Care Physician: _____ Practice Name:_____
- Hospital: _____ Other:_____

☐ **Entire record**
☐ Financial records
☐ Office visit notes
☐ Marketing* *Financial compensation is received for this communication
☐ Psychotherapy notes – if this box is checked only psychotherapy notes may be released.
☐ Diagnostic studies (list):
☐ Other as listed

Please release my health information TO:

Mecklenburg Heart Specialists
2711 Randolph Rd., Suite 305
Charlotte, NC 28207
Phone: (704) 334-0600 Fax: (704) 334-0615

I authorize Mecklenburg Heart Specialists to forward/release my records to the following doctors:
(Please list any specialists, etc. that you would like to have your records forwarded to on the line below)

_____

☐ **Send the information electronically. Email address: _____**

*For **email communication** I understand that if information is not sent in an encrypted manner there is a risk it could be accessed inappropriately. I still elect to move forward to allow email communications to occur.*

This authorization shall be in effect until the information has been forwarded as requested or until the course of treatment is complete.

Patient Rights:

- I have the right to revoke this authorization at any time.
- I may inspect or copy the protected health information to be disclosed as described in this document.
- Revocation is not effective in cases where the information has already been disclosed but will be effective going forward.
- Information used or disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.
- I may refuse to sign this authorization and that my treatment will not be conditioned on signing.
- I understand released information may include a communicable disease diagnosis such as HIV.

_____ Date: _____

Signature of Patient or Personal Representative

Description of Personal Representative's Authority (Attach necessary documentation)