



# River Region Cardiology

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## HIPPA AUTHORIZATION FOR RELEASE OF INFORMATION

### PATIENT INFORMATION

Name \_\_\_\_\_ Date of Birth \_\_\_\_\_

Social Security # \_\_\_\_\_

I hereby authorize the release of any information pertaining to my care, including diagnosis and medical records of any treatment or examination to me.

### **AUTHORIZATION FROM:**

\_\_\_\_\_

**RELEASED TO:** (Person/Organization receiving the information):

**River Region Cardiology, 114 Mitylene Park Lane, Montgomery, AL 36117**

Purpose of the release:

- Continued Medical Care
- Other (Please Specify): Transfer of Records

I understand the information released will be limited to information necessary to fulfill the need or purpose for the disclosure. If I have authorized the information to a recipient who is not subject to the Health Insurance Portability and Accountability Act of 1996 (HIPPA), then the recipient may re-disclose it and it may no longer be protected under HIPPA, a federal privacy law. This Authorization is valid for 120 days from the date of signature, unless otherwise noted. This authorization only applies to treatment occurring before the date of signature. I may decline to sign this Authorization. I understand I may revoke this authorization in writing at any time. If I revoke this authorization, the revocation will not apply to information that had already been released in response to this authorization. I understand the patient's health care and the payment for the patient's health care will not be affected if I do not sign this form. I understand I may see and copy the information described on this form if I ask for it, and I may receive a copy of this form after I sign it. I represent that I have the authority to and voluntarily grant permission for the information to be released as described above.

\_\_\_\_\_  
Signature of Patient

\_\_\_\_\_  
Date

\_\_\_\_\_  
Signature of Witness

\_\_\_\_\_  
Date