Merrimack Valley Cardiology Associates, Inc.

Robert M. Shulman, MD FACC Jose M. Carrion, MD FACC Richard G. Birkhead, MD FACC James B. Waters, MD FACC Harsh 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 Hong, MD

Patient Name: _____ DOB: _____
Address: _____

Patient Authorization For Release of Protected Health Information

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

Merrimack Valley Cardiology Associates, Inc.
Att: Medical Records
27 Village Square, Chelmsford, MA 01824
Phone: 978-256-6607
Fax:978-250-8189

PLEASE FAX TO: 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: Any prior cardiac testing: CT, MRI Echocardiograms, ETT Sress tests / Nuclear imaging, Cardiac Monitor reports, etc…

4: Hospital (Cardiology) Consults, History & Physical reports, Cardiac Procedure reports and Discharge Summaries

Patient/Legal Guardian Signature:_____
If Authorized individual, relationship to patient:_____
Date Signed:_____

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

_____
Patient / Guardian Signature