CardioVascular Consultants of Montana

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Family Release of Information

Patient Name:_____ **Date of Birth:**_____

Social Security #_____

CardioVascular Consultants of Montana is authorized to release protected health information pertaining to the patient named above to the entities and/or individuals below.

Entity/Individuals to Receive Information *(Check all that apply)*

_____Give information to Spouse _____

_____Give information to the following persons:

Name:_____Relationship:_____

Name:_____Relationship:_____

Name:_____Relationship:_____

_____ OK to leave information on voice mail

Description of Information to be Released *(Check all that apply)*

_____Medical Information: _____All or Specific_____

_____Financial information (ie. account balances, billing statements, insurance)

_____I DO NOT authorize the release of any information at this time

Patient Rights

I understand that I have the right to revoke this authorization at any time and that I have the right to inspect or copy the protected information to be disclosed as described in this document by sending a written notification to CardioVascular Consultants of Montana. I understand that a revocation is not effective in cases where the information has already been disclosed but will be effective going forward. I understand that information used to disclose as a result of this authorization may be subject to re-disclosure by the recipient and may no longer be protected by Federal and State law. I understand that I have the right to refuse to sign this authorization and that my treatment will not be conditioned on signing this authorization. This authorization shall be in force and effect until revoked in writing by the patient or representative signing the authorization.

_____ _____

Patient signature or Personal Representative Date