AUTHORIZATION TO RELEASE HEALTH INFORMATION

Provider: HEART CHECK AMERICA WASHINGTON D.C.

_______________________ _________________ MR#______________________
Service Date Appt. Time

ATTENTION: PLEASE PRINT ALL INFORMATION CLEARLY BELOW

I hereby authorize the above named provider to release my medical records to:

Patient Name: ____

Address: ____

City, State, Zip: ____

Home: (____)_______________ Cell: (____)______________ Work/Other: (____)______________

PLEASE NOTE: FOR SPEED IN TRANSMITTAL YOUR REPORT AND ITEMIZED STATEMENT WILL BE E-MAILED

____ **E-MAIL** (*please print clearly*): ____

Gender: ___ Male ___ Female (Could you be pregnant?) ___ Yes ___ No

D.O.B. _______________ Age: ________ Height: __________(inches) Weight: ___________

Ethnicity: [ ] Caucasian [ ] Asian/Pacific Islander [ ] African-American [ ] Hispanic [ ] Other

Please contact my physician if test results require immediate attention:

Physician Name: ____

Telephone: (____)____

*I understand that the Provider cannot be held liable or responsible for the re-disclosure of my medical records by any third party to whom I have approved release of such records.

Information to be released:

___ Heart Scan ___ Lung Scan ___ Abdomen/Pelvis Scan

___ Body Scan ___ Bone Density ___ Virtual Colonoscopy

I understand that I may revoke this authorization at any time by notifying Heart Check America in writing. Such revocation will:

1. Be effective as of the date received by Heart Check Washington, D.C., and
2. Not be effective as to information released pursuant to this authorization prior to Heart Check America's receipt of revocation.

Patient Signature: ______________________________________ Date: ____________________

Received By: ____ *Date:* ____________________