

AUTHORIZATION TO RELEASE HEALTH INFORMATION

Provider: HEART CHECK AMERICA, INC., ARLINGTON HEIGHTS, IL

Service Date _____ Appt. Time _____ MR# _____

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

____ **PHYSICIAN*** Name: _____

Address: _____

City, State, Zip: _____

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 America, Inc., 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: _____