LESLIE E. MEZEI, MD, FACC

REQUEST FOR MEDICAL RECORDS RELEASE
AUTHORIZATION TO USE OR DISCLOSE PROTECTED HEALTH INFORMATION

Patient's Name:_____ Date of Birth:_____

Address:_____

City:_____ State:_____ Zip Code:_____

I hereby authorize:
(Please check one)

( ) Premier Heart Group, LLC

( ) Other (Please Specify)_____
(Physician or Facility Name and Location) (Telephone/Fax Number)

To disclose information to:
(Please check one)

( ) Premier Heart Group, LLC

( ) Other(Please Specify)_____
(Physician or Facility Name and Location) (Telephone/Fax Number)

Treatment Date(s):_____ Purpose of Disclosure: ( ) Continuing Medical Care
( ) Other:_____

Specific Information to be Disclosed:

( ) All Records
( ) Office Note(s)
( ) Cardiac Testing _____
_____

( ) Lab Results
( ) History/Discharge Summary
( ) Other: _____
_____

I understand that the information in my health record may include information about behavioral and/or mental health services or treatment for alcohol or drug abuse. It may also include information regarding acquired immunodeficiency syndrome (AIDS) or human immunodeficiency (HIV).

I do not have to sign this authorization in order to receive treatment from Premier Heart Group, LLC. In fact, I have the right to refuse to sign this authorization. When my information is used or disclosed pursuant to this authorization, it may be subject to re-disclosure by the recipient and may no longer be protected by the federal HIPAA Privacy Rule. I have the right to revoke this authorization in writing except to the extent that the practice has acted in reliance upon this authorization. My written revocation must be submitted to the HIPAA Privacy Officer for Premier Heart Group, LLC at 121 St. Luke's Center Drive, Suite 501, Chesterfield, Missouri 63017.

I hereby authorize the disclosure of the above information. This authorization shall remain in effect for a period of six (6) months from the date indicated below.

_____ _____
(Signature of Patient or Legal Guardian) (Date)

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