



Palatine Heart Center

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AUTHORIZATION TO RELEASE PROTECTED HEALTH INFORMATION

Name of Patient (Print)

Street Address

Phone Number

City State Zip

Date of Birth

Last Four Digits of SSN (optional)

I hereby authorize Palatine Heart Center to release/obtain my records to/from:

*Please fill in the complete name and address of the medical facility or entity you would like your records sent to or obtained from.

The Protected Health Information I would like to have released is as follows (check one):

Release my entire chart (subject to state regulated per page fees)

I would like specific dates of service _____

I am requesting my information to be disclosed for the following reason: _____

I understand this authorization will expire 90 days from the date of signature.
I understand I may revoke this authorization in writing at any time.
I understand I am entitled to a copy of this authorization upon request.
I hereby acknowledge that the information I have given on this form with signature is true and correct.
I hereby acknowledge that I have read and fully understand the above statements as they apply to me.

Signature of Patient

Date

Signature of POA or other individual who has legal authority.

Date