Cardiovascular Specialists
of New England

Consent to Release Protected Health Information

Authorized by: ____________________ Legal Guardian/DPOA ______________________________

Physician/Practice may disclose the following health information(Check that apply):

All test results
The entire medical record
Today's chart note only

The following health information can not be disclosed (Check that apply):

All test results
The entire medical record
Today's chart note only
Other:

The purpose of the use/disclosure is (Check that apply):

Continued medical care
Employer's use
Family/spouse's employer's use
School use
Other:

This authorization is in force until:

One year
It is revoked inwriting

Disclosure to:

Spouse: ____

Children: ____

Others: ____

Okay to leave a voicemail at the following phone numbers: ______________________________

____ ______________________
Patient's Name (please print) DOB Date

____ ______________________
Patient / Guardian Signature Relationship to patient