SOUTHEAST CARDIOLOGY
Caring for the heart, from the heart

Nelson Gwinn III, MD, FACC, FSCAI
Christopher D. Centafont, DO, FACC

Board Certified Cardiologists

Kelli Key-Anderson, CRNP, NP-C
Tim Sorrells, CRNP, NP-C
Jeffrey Cook, CRNP, NP-C

Todd Ledford
Administrator

Authorization to Release Protected Health Information

Name (First, Middle, Last)	Date of Birth (Month/DD/YYYY)

Release information From

☐ Southeast Cardiology Clinic, Inc.
1150 Ross Clark Circle Dothan, AL 36301
Phone: 334.712.1929 Fax: 334.712.2799

☐ Other (Specify facility/individual & address below, including phone and fax numbers if known)

_____
_____
_____

Release Information To

☐ Southeast Cardiology Clinic, Inc.
1150 Ross Clark Circle Dothan, AL 36301
Phone: 334.712.1929 Fax: 334.712.2799

☐ Other (Specify facility/individual & address below, including phone and fax numbers if known)

_____
_____
_____

Purpose of Release

☐ Treatment/continued care
☐ Personal
☐ Other _____
☐ Legal Purposes
☐ Disability Determination

Delivery Method

☐ Mail
☐ Fax (paper or electronic)
☐ Pick up records
☐ Other _____

Information to be Released

☐ Clinical Notes ☐ EKG ☐ Diagnostic Testing ☐ Laboratory reports

☐ Other _____ Service Dates:
From: To:

I understand the information to be released may include records related to behavior and/or mental health care, alcohol and drug abuse treatment, HIV/AIDS, and genetics. The authorization may be revoked at any time except to the extent that action has been taken in reliance upon it. Revocation must be made in writing to the provider/facility releasing the information. The provider/facility will not condition treatment on whether I sign the authorization. I may be charged for copies in accordance with state law. Information used or disclosed pursuant to this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal law.

This authorization will expire one year from the date of singing unless I indicate an earlier date or event here: _____

Signature (Required)	Date (Required)

Printed name of person signing (If Not Patient)	
Mailing Address of Patient (Street, City, State, Zip Code)	Phone ( )

Staff member releasing PHI: _____Date:_____