Alderfer & Travis Cardiology, P.C.
670 Lawn Avenue
Suite 3A
Sellersville, PA 18960
215-257-9500

Consent for Release of Information to/from Alderfer & Travis Cardiology, P.C.

Patient Name:	Soc Sec #:	DOB:
Patient Address:		Telephone:

I, Do hereby consent to authorize:

_________________, to disclose medical information as listed below to ____________________
This information release is for the purpose of providing medical information relating to my identity , diagnosis, prognosis, or treatment. I do not give permission for another use or re-disclosure of this information.

ATTENTION PATIENT!

Please be alerted that, if any one of the following three (3) boxes is checked, it is with the intention of making you aware that your records contain "PROTECTED" information related to these categories. Therefore, your signature next to the identified category acknowledge your awareness of this fact.

I further understand that there is specific documentation within my records which is protected under the:

______________________ □ Confidential Alcohol & Drug Abuse Patient Information, 42 C.F.R. Part II
______________________ □ PA Mental Health Procedure Act
______________________ □ Confidentiality of HIV-Related Information Act, PA Law Act 148

I also understand that my record may contain:

- Drug or alcohol information, if drug or alcohol tests were ordered or treatment provided by my physician
- Psychiatric or psychological information, if psychiatric or psychological treatment was given by my physician
- HIV related information, if HIV related tests were ordered by my physician

The information to be released is:

□ History & Physical	□ X-Ray/Imaging Report	□ Other Studies:___________
□ Discharge Summary	□ Laboratory Results	□ Entire Record
□ Consultation Report	□ EKG, Stress Test, Echo	□ Date(s) of service
□ Operative/Procedure Report	□ Allergy Testing Results	□ From: To:
□ Pathology Report		

I also understand that this consent may be revoked by me at any time by submitting a written revocation notice, except to the extent that action has been taken in reliance thereon, and that this consent will remain in force in order to effectuate the purposes for which it was given.

Date:	Month:	Day:	Year:

Patient Signature: **Witness:**

Signature of Parent/Legal Guardian/ Authorized Representative:

□ Unable to sign because: