

ALFIERI CARDIOLOGY, P.A.
RECORDS REQUEST

AUTHORIZATION TO RELEASE TO ALFIERI CARDIOLOGY, P.A.

To: _____
(Doctor or Hospital)

(Address including City, State and Zip)

(Telephone Number of Provider, if known) (Fax Number of Provider, if known)

I hereby authorize and request the medical records of _____ be released to:

ALFIERI CARDIOLOGY, P.A.

and mailed to **one** of the following addresses:

701 Foulk Road
Suite 2B
Wilmington, DE 19803

G-39 Omega Drive
Newark, DE 19713

2600 Glasgow Avenue
Suite 103
Newark, DE 19702

This is an authorization under the Privacy Rules of the Health Insurance Portability and Accountability Act of 1996 [45 CFR para 164.508]. It authorized the Provider mentioned above to release my records to Alfieri Cardiology, P.A. and is valid for a period of one year unless I revoke it sooner by sending a note to the Provider mentioned above. All the Records of the patient mentioned above are to be released, unless noted below:

If only partial records are to be released, they are specifically noted as _____

Patient Name: _____ Date of Birth: _____

Patient Address: _____

Social Security Number: _____ Marital Status: _____ Sex: _____

Signature: _____ Date: _____

Witness: _____ Date: _____