Cardiovascular Center, P.A.
Dr. M. R. Lakshmi Narasimhan M.D.
264 Memorial drive Jacksonville, NC 28546
Phone: (910) 455-7001 Fax: (910) 455-9778 Phone: 910) 455-0578

Authorization to Release Health Information

Patient Information

Name of Patient: _____ DOB: _____

Address: _____ City, State, Zip: _____

Name & Address of Covered Entity authorized to release information:

_____

_____

_____

_____

Forward information to:

CARDIOVASCULAR CENTER PA
DR MR LAKSHMI NARASIMHAN
264 MEMORIAL DRIVE
JACKSONVILLE NC 28546
☎ 455 7001 Fax: 455 9778

These records are to include:

_____

_____

_____

_____

THIS AUTHORIZATION SHALL BE IN EFFECT UNTIL THE INFORMATION HAS BEEN FORWARDED AS REQUESTED.

Rights of the Patient:

I understand that my treatment will not be conditioned on signing this authorization and that I have the right to refuse to sign this authorization. *I understand that information disclosed as a result of this authorization may be subject to redisclosure by the recipient and may no longer be protected by federal or state law.*

I understand that I have the right to revoke this authorization by sending a written notification to the address below and that a revocation is not effective if the information has already been disclosed but will be effective going forward.

I understand that I have the right to inspect or copy the protected health information as described in this document. I can do this by written notification to: **Cardiovascular Center, PA – 231 Memorial Drive, Jacksonville, NC 28546**

Patient Name (Please print) _____

_____ **Date:** _____

Signature of Patient or Personal Representative:

_____

Description of Personal Representative's Authority (attach necessary documentation)