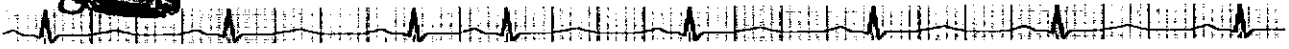




**Cardiovascular Center, P.A.**  
**Dr. M. B. Lakshmi Narasimhan M.D.**  
 264 Memorial Drive Jacksonville, NC 28546  
 Phone: (910) 455-7001 Fax: (910) 455-9778 Phone: 910) 455-0578



**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)** \_\_\_\_\_

\_\_\_\_\_  
**Signature of Patient or Personal Representative:** \_\_\_\_\_ **Date:** \_\_\_\_\_

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