MEMPHIS CARDIOVASCULAR CENTER
Dr. Bashar Shala
6799 Great Oaks Dr #100
Memphis, TN 38138
Phone: 901-751-0402 ó Fax 901-751-9688

Authorization for release of information:

For information about how your medical information may be used or disclosed, please see the patient notice. You have the right to review the notice before you decide to sign this form. The notice is subject to change. You may request a copy of the notice from the privacy officer of Consolidated Medical Practices of Memphis PLLC. The notice is also posted in our office.

- You have the right to inspect, copy, and/or amend information to be used or disclosed
- You may refuse to sign this form, however, it may prevent us from completing a task you have Requested (such as enrollment in research study or examining you to create a report for your attorney)
- We will not condition your treatment on an authorization, except for an authorization for research-related treatment
- We must provide you with the copy of this authorization form upon request

This authorization is voluntary
TO BE COMPLETED BY THE PAIENT OR PATIENT REPRESENTATIVE

I, ____Date of birth_______________ SS#____________
Do hereby authorize Consolidated Medical Practices of Memphis to obtain, use, disclose or receive my individually identifiable health information as disclosed below. I understand this authorization is voluntary. I understand that if the organization to whom I authorize disclosure of my personal data and/or individually identifiable health information is not a health plan, health care provider, or clearinghouse that the released information may no longer be protected by federal privacy regulations.

_______A. Complete medical record that may contain treatment notes regarding radiology, pathology (including HIV test results and genetic testing), immunization, procedure(s), alcohol and drug abuse records protected by Federal Confidentiality Rules 42 CFR Part 2, and other common medical documentation made by the physician, nurse or other ancillary personnel for the entire time I was treated by the practice.

_______ B. Records to be released and dates: ____

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I understand that I may withdraw my authorization in writing, except to the extent actions has been taken in reliance on this statement. I understand even if I do not withdraw authorization that this statement will expire one (1) year from this date. I have carefully read and understand the above, and to herein expressly and voluntarily authorize the disclosure of the above information about, or medical records of, my condition to these persons or agencies listed above.

____ ______________________
Signature of patient or patientøs representative Date
(form must be completed before signing)
Printed name of patient representative ____

Description of the representativeøs authority to act for the patient _____________________________________

Relationship to patient ____