



**ACADEMIC CARDIOLOGY ASSOCIATES, P. C.**

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1701 South Blvd East Suite 390, Rochester Hills, MI 48307 (248) 293-0055 Fax (248) 293-3348

**AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION**

Date:  
Patient Name:  
Address:  
Telephone Number:  
Date of Birth:

**RELEASE INFORMATION TO ACA**

1a) I authorize

\_\_\_\_\_  
\_\_\_\_\_

NAME AND ADDRESS OF DOCTOR, HOSPITAL

Phone number

to release information to:  
Academic Cardiology Associates 1701 South Boulevard East Rochester Hills, MI 48307  
Fax 248-293-3348

**OR**

**RELEASE INFORMATION TO ANOTHER HEALTH CARE FACILITY**

1b) I authorize ACA to disclose information contained in my medical record to:

\_\_\_\_\_  
PHYSICIAN or CLINIC NAME

\_\_\_\_\_  
ADDRESS CITY, STATE ZIP CODE

\_\_\_\_\_  
PHONE NUMBER FAX NUMBER

Specific information to be disclosed:  
History and Physical \_\_\_\_\_  
Lab reports \_\_\_\_\_  
Discharge Summary \_\_\_\_\_  
All Cardiac Testing \_\_\_\_\_  
Clinic Records \_\_\_\_\_  
Other \_\_\_\_\_  
All records from last two years \_\_\_\_\_

(Signature Next Page)

I understand that medical information may include if applicable: Alcohol and/or drug abuse and/or mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II. Information about Human Immunodeficiency Virus - HIV, acquired immunodeficiency syndrome - AIDS, and AIDS related complex - ARC, as defined by Department of Public Health rules (1989 Public Act 174). Third Party Information. Patient's

I understand that I may revoke this authorization at anytime and that it will remain in effect for a period of 12 months from the date signed. This authorization pertains to fulfillment of the above stated purpose(s). I have read the above, and acknowledge that I am familiar with and fully understand the terms and condition of this authorization.

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Patient signature

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Date