CARE 4 YOUR HEART
CARDIOVASCULAR DISEASE TREATMENT & PREVENTION
KATHLEEN J. DRINAN, DO, FACC

AUTHORIZATION AND RELEASE OF INFORMATION FOR PATIENT'S MEDICAL RECORDS TO KATHLEEN DRINAN, DO., LTD

To:_____
(Physician/Facility name and address

I hereby authorize and request you to release to Dr. Kathleen J. Drinan the complete medical records concerning my illness and/or treatment during the following period of time:

From:_____ To:_____

I fully understand that my medical record and/or information in connection with the treatment dates stated above may contain mental health, developmental disabilities, alcohol and drug abuse, and/or acquired immune deficiency syndrome (AIDS) and/or HIV test results and other confidential information.

This authorization shall be in effect for sixty (60) days following the date of signature. A photocopy of this authorization shall constitute a valid authorization. However, I may revoke this authorization at any time (except to the extent that action has already been taken in good faith on this authorization) by and only by submitting a written revocation request.

I hereby release, waive, discharge and hold harmless Kathleen J. Drinan, DO., Ltd., its owner, employees, agents and their heirs and successors and assigns from any and all liability, costs, and damages arising directly or indirectly in connection with the forgoing release of information.

Patient's Name_____ Date of Birth _____

Address:_____

Daytime Phone:_____

Signature:_____ Date:_____