David M. Stieber, MD Interventional & Consultative Cardiology

AUTHORIZATION TO RELEASE HEALTH CARE INFORMATION

Patient's Name:_____DOB:_____

SSN:_____Previous Name:_____

I request and authorize _____ to release health care information of the patient named above to:

Name:_____

Address:_____

City: _____ State: _____Zip Code:_____

For the purpose of:

_____

This request and authorization applies to:

___ Health Care information relating to the following treatment, condition or dates of treatment

_____

___ All Health Care Information

___Other_____

If a minor consented to heath care without parental consent for his/her own treatments, then the minor must consent or release of health care information. Dr David Stieber, MD FACC, Inc. is hereby released from all legal responsibility or liability for the release of the above-mentioned information. Once disclosed, the law does not always require the recipient of your information to maintain the confidentiality of your health care information. You are entitled to a copy of the authorization. You may revoke this authorization by a written request.

Signature of Patient:_____Date:_____

Signature of guardian or authorized person to consent for this patient:

_____Date: _____

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