PAUL M POPPER, MD, PA

AUTHORIZATION FOR RELEASE/RECEIPT OF HEALTH INFORMATION

Paul M Popper, MD, FACC, FSCAI
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Patient Name _____ Date of Birth _____

Patient Address: _____

_____Email_____

Telephone _____Social Security #_____

I authorize Paul M Popper, MD, PA ***(CHECK ONE OPTION)***

[ ] Obtain my records from **[ ] Send my records to**

_____

Name of physician or facility

_____

Street address **City** **State** **Zip Code**

_____

Telephone and/or Fax #

For the purpose: [ ] Continued Medical Care [ ] Personal Use [ ] New Patient Appt Date_____

Covering the period(s) FROM _____to_____

List specifically the information to be released: ○COMPLETE CHART ○H&P ○CARDIAC CONSULT ○PROGRESS NOTE/PATIENT ED SHEET ○PROBLEM LIST ○MEDICATION SHEET ○EKG ○LABS x1 year ○PFT ○MCOT ○HOLTER ○CXR ○ ARTERIAL US ○VENOUS US ○CAROTID US ○ECHOCARDIOGRAM ○STRESS TEST ○CARDIAC CATHETERIZATION ○ANGIOPLASTY/STENT ○PERIPERHAL ANGIOGRAM/STENT ○PACER/ICD OP REPORT ○PPM/ICD/DEVICE CHECK ○OPEN HEART SURGERY REPORT-CABG OR VALVE

○OTHER_____

_____

I hereby release Paul M Popper, MD, PA and its employees, agents, officers, and affiliates from any and all liability, responsibility, claims and damages which may result from the release of information authorized by this Release/Receipt of Health Information.

I understand that my records may contain information about alcohol and/or drug treatment, mental health, or psychiatric treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information, as specified, for the purpose or need as indicated above.

I understand that Paul M Popper, MD, PA may utilize a medical record correspondence service and that there may be a fee assessed for this service. (Please allow 7 to 10 business days for records to be copied.)

I understand that this consent will expire six (6) months after the date below, or when the information requested with this consent has been released.

I have read and understood the Release/Receipt of Health Information and have voluntarily and knowingly signed such consent

A photocopy of this authorization shall have the same effect as the original.

_____ _____ _____
Signature of patient or legal representative Relationship to Patient Date

_____
Witness

OFFICE USE ONLY- DO NOT WRITE ON THESE LINES
Date request received_____
Medical Record Number_____
☐ To desk of upon receipt _____