BARONE & CATANIA
CARDIOVASCULAR GROUP, PC

*Dr. Paul Barone, DO, FACC* *Dr. Raymond Catania, DO, FACC*

# General Medical Records Release and Authorization for Use or Disclosure of Protected Health Information

Please complete the following information:

Patient Name: _____

Address: _____

_____

Phone: _____

SSN: _____ Date of Birth: _____/_____/_____

I authorize the custodian of records of:_____ or other person/entity (specifically describe) _____ to disclose/release the following information* (check all applicable):

- ☐ All records
- ☐ Laboratory/pathology records
- ☐ X-ray/radiology records
- ☐ Visit Summary
- ☐ Other (describe specifically) _____

***Note:** If these records contain any information from previous providers or information about HIV/AIDS status, cancer diagnosis, drug/alcohol abuse, or sexually transmitted disease, you are hereby authorizing disclosure of this information.*

These records are for services provided on the following date(s): _____

Please send the records listed above to :

- ☐ Barone & Catania Cardiology
  786 Mountain Blvd, Watchung NJ 07069
  P: 908-754-0975 F: 908-754-0260
- ☐ (Other) Name:_____
  Address:_____
  Phone/Fax:_____

The information may be used/disclosed for each of the following purposes:

- ☐ At my request (only the patient can check this box)
- ☐ For my health care
- ☐ For payment/insurance
- ☐ For employment purposes
- ☐ Other:

By signing below I represent and warrant that I have authority to sign this document and authorize the use or disclosure of protected health information and that there are no claims or orders pending or in effect that would prohibit, limit, or otherwise restrict my ability to authorize the use or disclosure of this protected health information.

_____ _____

Signature of patient (or patient's personal representative) Date

_____ _____

Printed name of patient representative Representative's authority to sign for patient, *(i.e paren, guardian, power of attorney for healthcare, executor*