SAINT FRANCIS MEDICAL PARTNERS
CAPE CARDIOLOGY GROUP

211 Saint Francis Drive, Suite 15
Cape Girardeau, MO 63703
Phone: 573-331-3333
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CONSENT FOR THE RELEASE OF CONFIDENTIAL INFORMATION (please print)

PATIENT NAME: _____

SS#: _____ D.O.B.: _____ AGE: _____ SEX: _____

ADDRESS: _____ CITY/STATE: _____ ZIP: _____

ATTENDING DOCTOR: _____ APPROXIMATE DATE OF TREATMENT: _____

I (We), the undersigned, _____, hereby authorize

Cape Cardiology Group to release to: _____

at address: _____

The purpose/need for the disclosed information is: **for continued medical care**

This consent authorizes the release of information that is considered confidential. It is intended for use of the specified agent or agency only or such agency to whom redisclosure of this information is necessary to accomplish its service. The agent or agency will make no further disclosure of this information without the written consent of the patient to whom it pertains. In the case of records containing information related to drug or alcohol treatment, this confidentiality is protected by Federal Regulation (42 CFR Part 2). The undersigned may revoke this consent at any time, except to the extent that action has been taken in reliance upon this consent and the undersigned agrees to fully indemnify and hold harmless Cape Cardiology Group from any liability for release of the information under the authority of this consent.

_____Unless signed here, medical records regarding drug/alcohol use or abuse, HIV/AIDS testing and results, mental health, and communicable diseases will not be released.

This consent shall expire on _____ (90 days from date signed) unless sooner revoked in writing and delivered to Cape Cardiology Group.

The undersigned further states that the matters stated above are true and that falsification of this is prohibited by 42 CFR Part 2, section 2.31.

SIGNED: _____ (Person consenting to the release)

PRINT NAME: _____ DATE: _____

WITNESS: _____ PRINT NAME: _____ DATE: _____
(Person witnessing signature)