

Authorization for Release of Information

I authorize Los Angeles Cardiology Associates to release all medical information (including, but not limited to, information on psychiatric conditions, sickle cell anemia, alcohol and drug abuse, and HIV or communicable diseases) requested by my health insurance carrier, Medicare or any other third-party payers.

I authorize Los Angeles Cardiology Associates to release all medical information to my referring physician and my primary (family) physician.

I authorize Los Angeles Cardiology Associates to contact my insurance company or health plan administrator and obtain all pertinent financial information concerning coverage and payments under my policy.

I direct the insurance company or health plan administrator to release such information to Los Angeles Cardiology Associates.

I agree that these provisions will remain in effect until I provide written revocation to Los Angeles Cardiology Associates.

Signature of Patient/Legal Guardian: _____

Date: _____