Cardiovascular Specialists of New England

Consent to Release Protected Health Information

Authorized by: _____ Legal Guardian/DPOA: _____

Physician/Practice may disclose the following health information (Check that apply):

- ☐ All test results
- ☐ The entire medical record
- ☐ Today's chart note only
- ☐ Billing

The following health information cannot be disclosed (Check that apply):

- ☐ All test results
- ☐ The entire medical record
- ☐ Today's chart note only
- ☐ Other: _____

The purpose of the use/disclosure is (Check that apply):

- ☐ Continued medical care
- ☐ Employer's use
- ☐ Family/spouse's employer's use
- ☐ School use
- ☐ Other: _____

This authorization is in force until:

- ☐ One year
- ☐ It is revoked in writing

Disclosure to:

Spouse: _____

Children: _____

Others: _____

Okay to leave a voicemail at the following phone numbers: _____

All printed names below will serve as your signature:

_____ _____ _____

Patient's Name (please print) DOB Date

_____ _____

Guardian Name (if applicable) Relationship to Patient (if applicable)

Once this form is completed, **download to your computer first.** Open the PDF file, then click SUBMIT to email to CSNE. >