

Account# _____

CARY CARDIOLOGY,P.A.

Authorization to Release Information

By signing this form, you are authorizing Cary Cardiology to release any information acquired in the course of your examination or treatment to specific insurance carriers, third party payers or others involved in processing and collection of payment for services in accordance with the HIPAA Patient Confidentiality Act of 1996.

Authorization for Treatment

My signature on this form indicates that I hereby authorize treatment for myself, or the patient, by Cary Cardiology, P.A. and its affiliates.

_____ Date _____
Signature of Patient or Responsible Party

Relationship to Patient _____