Authorization to release records

Use one form for each practice. Complete both pages, read the limits, and sign on page 2. Save the PDF to fill it in, then print and sign, or use a signature method accepted by the releasing practice.

1. Patient

Full legal name

Date of birth (MM/DD/YYYY)

Other name used in these records (if any)

Practice record number (if known)

2. Practice authorized to release records

Full name of practice, hospital, or other record holder

Records department mailing address

Records department phone or secure fax (if known)

3. Who may receive the records

Plain Spoken Health, including its physician and authorized records-coordination staff. Purpose: at my request, to obtain and organize the selected records and support my cardiology educational review.

Secure upload is preferred. Obtain the private delivery link from Plain Spoken Health before signing. If the practice needs fax, obtain a confirmed healthcare fax destination. Do not use the public inquiry email.

Private upload destination; confirmed healthcare fax only if needed (required)

4. Specific records to release

Records dated from (MM/DD/YYYY)

Through (MM/DD/YYYY)

Select only the report types needed. The exclusions on page 2 apply to every selection.

- ☐ Cardiology / relevant primary-care notes
- ☐ Cath / interventional procedure reports
- ☐ Echo / stress-test reports
- ☐ ECG / rhythm-monitor reports
- ☐ Relevant lab results
- ☐ Medication and allergy lists
- ☐ Written CT / MRI reports
- ☐ Relevant consult / discharge summaries

Your choices and signature

Patient full legal name (repeat from page 1)

Date of birth (MM/DD/YYYY)

Relevant condition, visit, or report details; other limits on this request

5. Information this form does not authorize

Do not release psychotherapy notes; mental-health treatment information; alcohol or substance-use treatment records (including records protected by 42 CFR Part 2); confidential HIV-related information; or genetic-test information under this form. Use a separate, appropriate authorization if any of these records are needed. Do not include billing records, insurance documents, or original imaging files.

If a selected report includes excluded information, the releasing practice should withhold that information and tell us the request needs clarification or a separate authorization. This form permits written copies and administrative communication about obtaining them. It does not authorize discussion of my medical care.

6. Expiration

This authorization expires **180 days after the signature date**, unless I enter an earlier date below. It covers only the record dates and types I selected, not future care.

Earlier expiration date, if desired (MM/DD/YYYY)

7. Your rights

Signing is voluntary. My treatment, payment for treatment, health-plan enrollment, and eligibility for benefits will not depend on signing. If I do not sign, Plain Spoken Health cannot collect records under this form; I may obtain my own copies instead.

I can revoke this authorization in writing. Send the revocation to the records department of the practice in section 2. Notify Plain Spoken Health through its agreed secure channel as well. Revocation does not undo disclosures or other actions already taken in reliance on this authorization.

Redisclosure. Information released to the recipient could be disclosed again and may no longer be protected by HIPAA. Other applicable privacy laws may still protect it. I am entitled to a copy of this signed authorization. It does not authorize marketing, sale of my information, or payment.

8. Authorization and signature

I authorize the practice in section 2 to release the records selected on these two pages to the recipient in section 3, subject to the limits above. I have completed the required details and had an opportunity to ask questions.

Date signed (MM/DD/YYYY)

Patient or authorized representative signature (not a typed name)

Representative name, if signing for patient

Legal authority (attach documentation if needed)