

**AUTHORIZATION TO OBTAIN OR RELEASE MEDICAL  
RECORDS FROM MEDICAL PROVIDERS**

I hereby authorize NEWPORT HEART MEDICAL GROUP to obtain any and all medical records concerning my care from any physician, hospital or other health care professional that has provided medical care to me in the past.

I also authorize NEWPORT HEART MEDICAL GROUP to release any and all medical records concerning my care to any physician; hospital or other health care professional providing care to me at any time. Additionally, I authorize NEWPORT HEART MEDICAL GROUP to release any and all medical records concerning my care to Medicare, Medi-Cal, any insurance company, third party administrator, or managed care company.

\_\_\_\_\_

Patient Signature	Date
-------------------	------

\_\_\_\_\_

Print Name	Date of Birth
------------	---------------

**AUTHORIZATION TO RELEASE MEDICAL INFORMATION TO  
INDIVIDUALS/FAMILY MEMBERS**

In accordance with federal government privacy ruled implemented through the Healthcare Portability Act of 1996 (HIPPA), in order for your physician or staff at NEWPORT HEART MEDICAL GROUP to discuss your condition with members of your family or other individuals that you designate, we must obtain your authorization prior to doing so.

\* In the event of a critical episode or if you are unable to give your authorization due to severity of your medical condition, the law stipulates that these rules may be waived.

\_\_\_\_\_ I do not authorize NEWPORT HEART MEDICAL GROUP to release any or all information concerning my medical care to any individual except as set forth above (\*).

\_\_\_\_\_ I authorize NEWPORT HEART MEDICAL GROUP to verbally release any or all information concerning my medical care to the following individuals:

_____	_____
Name	Relationship

_____	_____
Name	Relationship

\_\_\_\_\_

Patient Signature	Date
-------------------	------