



SKYLINE CARDIOVASCULAR INSTITUTE, PLC

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AUTHORIZATION TO RECEIVE MEDICAL RECORDS

Please complete this form, and return it to an SCI staff member.

Patient name: _____

Address: _____

SSN: _____ DOB: _____

By completing and signing this authorization, I consent to and request that:

(Physician or clinic name)

release my health information to Ronald I. Weiner, D.O., and the Skyline Cardiovascular Institute, for the purpose of continuing medical care. These records may be mailed to the above address or faxed to the phone number listed above.

When information is used or disclosed pursuant to this authorization, it may be subject to subsequent disclosure(s) by the recipient and may no longer be protected by the federal HIPAA privacy rule. You have the right to revoke this authorization in writing to the extent that the practice has acted in reliance upon this authorization. Written revocation must be submitted to the privacy officer at the Skyline Cardiovascular Institute, PLC, at the address listed above.

This authorization will expire twelve months from the date below unless another date is specified. At all times, the Skyline Cardiovascular Institute fervently adheres to all HIPAA laws regarding patient privacy and confidentiality.

Patient signature: _____

Date: _____

Patient printed name: _____