Barry S. Denenberg, MD, FACC
R. Alberto Rosa, MD, FACC
Kenneth P. Sunnergren, MD, FACC
G. Robert Myers, MD, FACC
Ajith Kumar, MD
Penny F. Johnson, DNP, CRNP
Samantha Eckrote, FNP
Carlos A. Neves, MD
Sean Ryan, MD
Kevin Caldwell, MD
Jillian Zuppo, FNP

Patient ID:___________________

Date: ______________________

Medical Records Release

□ Records to request from: ____
(Include correct spelling, phone and fax number)

□ Records to be sent to: ____
(Include correct spelling, phone and fax number)

I hereby authorize you to use or disclose the specific information described below, only for the Purpose and parties also described below:

□ Medical Records only □ Include mental health records

□ Include drug and alcohol records □ Include STD records

□ Include HIV records □ Include genetic information records

Entity requesting the information and authorized to make the requested use:

Cardiovascular Consultants of Southern Delaware

□ Lewes, 16704 Kings Highway, Lewes, DE 19958, (302) 645 1233(p); (302) 645 1228(f) ***or*** (302) 644 3826(f)

□ Millville, 35141 Atlantic Avenue, Unit 3, Millville, DE 19970, (302) 541 8138(p); (302) 541 8425(f)

Vascular Surgeons of Southern Delaware

□ Lewes, 33664 Bayview Medical Drive, Unit 2, Lewes, DE 19958, (302) 644 4954(p); (302) 645 5481(f)

This information is being requested for the following purpose(s):

□ Medical Treatment □ Legal Proceeding □ Insurance Purposes □ Other: __________________

This authorization shall remain in effect from the date signed below until: ________________________
(*Expiration date/event*)

I understand that:

- I may inspect or copy the protected health information to be used or disclosed
- I may revoke this authorization in writing by contacting your office at the address above, Attention: Privacy Officer
- Information used or disclosed pursuant to the authorization may be subject to re-disclosure by the recipient and no longer is protected by HIPAA
- I may refuse to sign this authorization and that you will not condition treatment or payment on my providing this authorization (except to the extent that the authorization is for research/ related treatment, in which case you may refuse to provide that research-related treatment)
- I acknowledge that I have received the "Notice of Privacy Practice" and authorize **CVCDE** to Release or obtain my private information for the purposes of my treatment, to obtain payment from a third party or conduct normal healthcare operations, per the Health Insurance Portability and Accountability Act of 1996.

PRINTED Patient Name: ____

Signature: ____

Last four digits of Social Security: __________________________ Date of Birth: ____________________________

If signed by personal representative, please include printed name and relationship: _________________________________

Cardiology
Lewes Office:
16704 Kings Highway
Lewes, De 19958-4929
(302) 645 1233 phone
(302) 645 1228 fax
Millville Office:
35141 Atlantic Avenue
Unit 3
Millville, De 19970-6954
(302) 541 8138 phone
(302) 645 1228 fax

Vascular
Lewes Office:
33664 Bayview Medical Drive
Unit 2
Lewes, De 19958-4929
(302) 644 4954 phone
(302) 645 5481 fax