

# **LGH MERRIMACK VALLEY CARDIOLOGY ASSOCIATES, LLC**

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## **Patient Authorization For Release of Protected Health Information**

**PLEASE FAX TO (978) 250-8189**

Date: \_\_\_\_\_ Name (please print): \_\_\_\_\_ DOB: \_\_\_\_\_

Address: \_\_\_\_\_

I, \_\_\_\_\_, hereby authorize release of my protected health information (information contained in my medical record) to the following entity:

LGH Merrimack Valley Cardiology Associates, Inc.

Attn: Medical Records

14 Research Place, North Chelmsford, MA 01863

Phone: (978) 256-6607 · Fax: (978) 250-8189

### **Description of Information to be Disclosed: ANY OF THE FOLLOWING RECORDS**

1. Most Recent Office Visit Note
2. Recent Blood Lab Results/Prior EKG
3. Prior Cardiac Testing: CT, MRI Echocardiograms, ETT Stress Tests/Nuclear Imaging, Cardiac Monitor Reports, etc.
4. Hospital (Cardiology) Consults, History/Physical Reports, Cardiac Procedure Reports/Discharge Summaries

Patient/Legal Guardian Signature: \_\_\_\_\_

If authorized individual, relationship to patient: \_\_\_\_\_

### **HIPAA – Notice of Privacy**

I acknowledge having received a copy of the practice's Notice of Privacy Practices.

Patient / Guardian Signature: \_\_\_\_\_

### **Patient Financial Responsibility**

Your signature on this form indicates that you are responsible for all fees and charges for services you receive that are not covered under your health plan. Please remember that it is your responsibility to confirm with your health plan whether the services provided to you will be covered by your insurance.

Patient / Guardian Signature: \_\_\_\_\_

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*Stress Testing · Echo and Nuclear Stress Testing · Echocardiography · Cardiac CT · Event Monitoring · Holter Monitoring  
Pacemaker and Defibrillator Insertion and Management · Cardiac Catheterization · Angioplasty · Interventional Cardiology  
Peripheral Vascular Interventions · Carotid and Peripheral Vascular Ultrasonography · Electrophysiology Evaluation and Therapy*

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[www.mvcardiology.com](http://www.mvcardiology.com)