Advanced Cardiac Healthcare, P.L.C.

Satellite Locations:
Kalamazoo (Borgess & Westside)
Allegan • Battle Creek • Paw Paw • Vicksburg

601 John Street, Suite 100, Kalamazoo, MI 49007 ▪ (269) 373-1222 ▪ 1-800-483-8333 ▪ Fax (269) 373-6270

Douglas J. Wunderly, MD ▪ Joel H. Reinoehl, MD ▪ Christopher Rogers, DO ▪ John F. Schonder, MD
Michael S. Pawlik, DO ▪ Robert A. Williams, DO ▪ Thomas A. Keller, MD ▪ Brett J. Eliuk, DO ▪ Michael A. Pack, DO

AUTHORIZATION FOR RELEASE OF MEDICAL INFORMATION

Patient Name: _____ Date of Birth: _____

Address: _____

Telephone Number: _____

1) I authorize _____
Name of Doctor/Medical Facility

_____
Address

_____
Phone Number

to release information to: Advanced Cardiac Healthcare, PLC
601 John Street, Suite 100
Kalamazoo MI 49007

Phone: (269) 373-1222
Fax: (269) 373-6270

2) I understand that medical information may include, if applicable:
Alcohol, drug abuse and mental health treatment information protected under the regulations in Title 42 of Code of Federal Regulations Part II. Information about human immunodeficiency virus - HIV, acquired immunodeficiency syndrome - AIDS, and AIDS related complex - ARC, as defined by Department of Public Health rules (1989 Public Act 174).

3) Specific information to be disclosed (please include dates of treatment):

History & Physical: _____ Last office visit: _____

Lab Reports: _____ Discharge Summary: _____

Clinic Records: _____ X-Rays: _____

EKG: _____ Holter: _____

Echocardiogram: _____ Stress Test: _____

OP Notes: _____ Other: _____

All records from last two years: _____

I understand that I may revoke this authorization at anytime and that it will remain in effect for a period of 12 months from the date signed. This authorization pertains to fulfillment of the above stated purpose(s).

I have read the above, and acknowledge that I am familiar with and fully understand the terms and condition of this authorization.

_____ _____
Patient, or parent or guardian signature Date