Boston Scientific Cardiac Diagnostic Services, LLC

1717 N. Sam Houston Pkwy, Suite 100 Houston, TX 77038
888.747.1442
www.CDx.BostonScientific.com

Authorization for Release of Patient Medical Information

To request release of medical information please complete and sign this form and return it by mail or fax to:

Boston Scientific Cardiac Diagnostic Services, LLC
Attn: Medical Records Department
1717 N Sam Houston Pkwy W, Suite 100
Houston, TX 77038
Fax: 281-760-0332 or 888-432-9522

If you need help completing this form, please contact the Monitoring Center at **888.500.3522**.

Patient Information		
Last Name	First Name	MI
Street Address		Apt. #
City	State	Zip
MRN	Home Telephone	
Date of Birth	Alternate Telephone	

I hereby authorize Boston Scientific Cardiac Diagnostic Services, LLC (formerly known as Preventice Services, LLC) to release reports and other information contained in my Medical Record. I understand this information has already been provided to my ordering physician.

Information Requested (please be specific and enter date of service if known)
Restrictions and / or Exclusions
Purpose of Release

Boston Scientific Cardiac Diagnostic Services, LLC will provide the information requested above to the following party ONLY:

Name			
Attention To	Telephone	Fax or Email	
Street Address	City , State	Zip	
Preferred Method of Delivery ☐ Fax ☐Email ☐Mail (USPS)			

I hereby authorize Boston Scientific Cardiac Diagnostic Services, LLC ("BSC CDx") to release any medical information as requested above. This may include information about arrhythmias, symptoms, activities or other protected health information unless otherwise excluded, except clinician notes. I am aware that BSC CDx cannot control how the recipient uses or shares the information, and that laws protecting its confidentiality at BSC CDx may or may not protect this information once it has been disclosed to the recipient.

Information will not be released without a valid signature below. This authorization will expire 90 days from the below signature date. I can, however, revoke this authorization in writing at any time, except to the extent that BSC CDx has relied upon it. For example, if I revoke this authorization after BSC CDx has sent requested records, BSC CDx will not retrieve those records.

I acknowledge that email is not a secure form of communication. BSC CDx takes steps to ensure the security and privacy of information, including providing encrypted email. If I have requested email as the means by which I would like my medical information provided, then I understand that BSC CDx will provide this information to me and/or the person I designated above via an encrypted email. I understand that treatment, payment, enrollment or eligibility of benefits may not be conditioned on signing this authorization, and BSC CDx will continue to provide care for current and future enrollments.

Signature of Patient (if 18 years of age or older) _____ Date _____

Signature of Personal Representative _____ Personal Representative's Title or Role (e.g., Parent, Guardian, Healthcare Power of Attorney, Executor or Administrator) _____ Date _____

Please make a copy of this release for your records.