Patient Authorization and Release of Health Records

When you complete and sign this form, patient health information will be released as described below.

Please read carefully and complete the required sections before signing.

PATIENT INFORMATION

Last name ____ First name ____ Middle name ____

Date of birth ____ Phone number ____

Address ____

AUTHORIZATION

I authorize iRhythm Technologies, Inc., to disclose (please describe the specific health information you would like released):

Email ____ Fax ____

If to be disclosed to someone other than Patient, please provide the name of the person(s) and address to whom iRhythm may make the disclosure:

Please indicate the reason you would like the health information released:

- ☐ Check here if you are the patient and you do not want to provide the reason.
- ☐ Check here if you are the patient's legal representative, and provide the reason for the release:

EXPIRATION

This authorization will automatically expire one (1) year from the date of signing unless a different end date is specified here:

PATIENT RIGHTS

- I may refuse to sign this authorization. My refusal will not affect my ability to obtain treatment or payment or eligibility for benefits.
- I may revoke this authorization at any time, but I must do so in writing and mail it to the following address: iRhythm Technologies, Inc., Attention: Customer Care, 3 Parkway North, Suite 400 Deerfield, IL 60015. My revocation will take effect upon receipt, except to the extent others have acted in reliance upon this authorization.
- I have a right to receive a copy of this authorization.

The health information that will be released as a result of signing this authorization could be re-disclosed by the recipient. If this occurs, the health information may no longer be protected by state and federal laws.

If you have questions about this authorization form or the release of health information, please contact iRhythm Customer Care at (888) 693-2401 or support@irhythmtech.com before signing this form.

Please sign and date this form to authorize iRhythm Technologies, Inc. to release the information as stated on this form.

If you are not the patient and you are signing this authorization form, describe your authority to sign on behalf of the patient and please provide supporting legal documentation:

SIGNATURE OF PATIENT OR LEGAL REPRESENTATIVE

Print name ____ Relationship to patient ____

Signature ____ Date ____

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