THE CARDIOVASCULAR CENTER OF FLORIDA

Authorization for Use of Disclosure of Protected Health Information Health Information Management Department

PLEASE PRINT ALL YOUR INFORMATION

Patient's Name: _____ **SS#:** XXX-XX-_____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Date of Birth: _____ **Phone #:** _____

OFFICE USE ONLY
_____ RCVD BY Initials/Date
_____ MAILED/FAXED Initials/Date
_____ PICKED UP Initials/Date

☐ **PERSONAL COPY, PICKING UP AT OFFICE (WRITE LOCATION)** _____

☐ **Send information to:** **OR** ☐ **Request information from:**

Facility/Practice/Name: _____

Attention: _____

Address: _____

City: _____ **State:** _____ **Zip Code:** _____

Phone #: _____ **Fax #:** _____

Purpose of Release (Continued Care, Personal, etc.): _____

☐ **ALL RECORDS** ☐ **ANY RECORDS FROM** _____ **TO** _____

Specific Items Needed: ☐ **Consults** ☐ **Stress Test** ☐ **Holter Monitor** ☐ **Echo**

☐ **Hospital Records** ☐ **LAB** ☐ **LEA** ☐ **Carotid** ☐ **EKG**

☐ **Other:** _____

☐ **Return information to:**

The Cardiovascular Center of Florida
Attn: Medical Records
7301 Stonerock Cir, Ste 1
Orlando, FL 32819
Fax (407) 705-2540
Phone (407) 738-4200

TO THE PATIENT

This authorization is for release of medical records, sensitive documents and information including diagnosis, treatment, and/or examination. As required by state and federal law, Cardiovascular Institute of Central Florida may not use or disclose your health information, except as provided in our Notice of Privacy Practices, without your authorization. Your signature on this form indicates that you are giving permission for the uses and disclosures of the protected health information described on this form.

I understand that state law prohibits the re-disclosure of the information disclosed to the persons/entities listed above without my further authorizations, but that Cardiovascular Institute of Central Florida cannot guarantee that the recipient of the information will not re-disclose this information contrary to such prohibition. I understand that I have a right to inspect and to obtain a copy of any information disclosed. I understand that this authorization will remain in effect for one (1) year or until I revoke it in writing. I understand that I may revoke this authorization at any time. I understand that if I revoke this authorization, I must do so in writing to Health Information Management, Cardiovascular Institute of Central Florida, 2111 SW 20th Place, Ocala, FL 34471. I further understand that any such revocation does not apply to the information already released in response to this authorization. I understand that I am under no obligation to sign this authorization. I further understand that my ability to obtain treatment will not depend in any way on whether I sign this authorization. I hereby release Cardiovascular Institute of Central Florida and all employees from any and all liability that may arise from the release of information as I have directed.

Patient's Signature: _____ **Date:** _____

Signature of Parent or Guardian: _____ **Date:** _____

Relationship to Patient: _____