THE CARDIOVASCULAR CENTER
OF FLORIDA

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

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:** _____

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

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

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

Facility/Practice/Name: Orlando Health

Attention: Medical Records

Address: 1222 S. Orange Ave

City: Orlando **State:** FL **Zip Code:** 32806

Phone #: 321-841-6444 **Fax #:** 321-843-6411

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

☑ **ALL CARDIOLOGY RECORDS**
☐ **LATEST RECORDS CHECKED BELOW**
☐ **ALL CARDIOLOGY RECORDS FROM** _____ **TO** _____

Specific Items Needed: ☐ **Consults** ☐ **Stress Test** ☐ **Holter Monitor** ☐ **Echo** ☐ **Hospital Records**
☐ **LABS** ☐ **LEA** ☐ **Carotid** ☐ **EKG**

☐ **Other:** _____

☑ **Return information to:** **The Cardiovascular Center of Florida**
Attn: Medical Records, Dr. _____
7301 Stonerock Cir, Ste 1, Orlando, FL 32819
Fax: 407-705-2540

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, The Cardiovascular Center of 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 The Cardiovascular Center of 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, The Cardiovascular Center of Florida, 7301 Stonerock Cir, Ste 1, Orlando, FL 32819. 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 The Cardiovascular Center of 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: _____