Authorization for Release of Medical Record Information

Patient's Legal Name: _________________________________ Date of Birth: ___________

I hereby authorize the following provider to release my protected health information:

Name: ____

Address: _________________________ City: _____________ State: __________ Zip: _______

Telephone: ________________ Fax: ______________________

Please mail or fax to:

Name: Florida Heart Associates, PL
Address: 1550 Barkley Circle, Fort Myers, FL 33907
Telephone: 239-938-2000 Fax: 239-278-0404

I understand that if the person or entity that receives the above information is not a health care provider or health plan covered by federal privacy regulations, the information may be subject to re-disclosure by recipient and no longer protected by Federal Privacy Rules. I understand that this authorization does NOT include AIDS/HIV, sexually transmitted disease, behavior /mental health, or alcohol/drug abuse information. I may indicate these in a separate release if desired.

Reason for disclosure:
Personal ❑ Continuation of Treatment ❑ Legal or Insurance ❑ Other ___________

Information to be disclosed:

- ❑ Catheterization**all
- ❑ Echocardiogram**most recent
- ❑ Nuclear/Stress Test**most recent
- ❑ Labs/Coumadin/Lipids**most recent
- ❑ Office Visit/Consult**last 2
- ❑ PVR**most recent
- ❑ MUGA**most recent
- ❑ Event Monitor**most recent
- ❑ Pacer check/implantation** most recent
- ❑ Holter**most recent
- ❑ Heart Surgery/Vascular Procedures
- ❑ ________________________

This authorization is in effect until _________________or for 6 months from date signed.

Signature of Patient or Legal Representative Date Relationship to Patient

As described in the Notice of Privacy Practices of Florida Heart Associates, PL, I understand that I may revoke this authorization in writing at any time, except to the extent that the action(s) have been taken as outlined by this authorization; the revocation must be in writing and sent to Florida Heart Associates, 1550 Barkley Circle, Fort Myers, FL 33907, ATTENTION: Privacy Officer. FHA will not condition treatment, payment, enrollment, or eligibility for benefits on whether I sign this authorization. I may be charged for copies of my medical records as allowable under Florida Administrative Code: 64B8-10.003.

_______________________________ ❑ **Share Care**
Name of FHA staff receiving request