Authorization for Release of Medical Record Information

I hereby authorize Florida Heart Associates, PL to release my protected information including any medical, psychiatric, HIV-related and/or substance abuse information from my medical record for the purpose of continuing patient care.

Patient's Legal Name: _____ **Date of Birth:** _____

Please release my protected health information to the following provider:

Name: _____

Address: _____ City: _____ State: _____ Zip: _____

Telephone: _____ Fax: _____

The information is to be delivered by: Mail ❑ Fax ❑ Patient pick-up_____

For Patient's requesting their information for themselves, there is a charge of $1.00 per page up to $25.00.

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.

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.

Florida Heart Associates 239.938.2000
Fax 239.278.0404

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