FLORIDA CARDIAC CONSULTANTS, INC.

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MEDICAL RECORDS RELEASE AUTHORIZATION

PLEASE READ AND COMPLETE THE ENTIRE FORM

Patient Name:_____ DOB:_____SS#:_____

Address:_____ Phone:_____

City:_____ State:_____ Zip:_____

I authorize Florida Cardiac Consultants to: (check one)

_____ SEND my records to: _____OBTAIN my records from:

_____
Name of Physician or Facility

_____
Mailing Address City State Zip

_____
Telephone Fax

For the purpose of: (check one)

____ Continued Care ____ Personal Use ____New Patient Appt. on:_____
____ Legal ____ Disability Claim ____ Other

LIST SPECIFICALLY THE INFORMATION TO BE RELEASED:

_____

_____

I understand that my medical records may contain information about drug and/or drug treatment, mental health or behavioral health treatment, and/or HIV/AIDS information. I do herein expressly and voluntarily consent to the disclosure of my health information as specified for the purpose of need as indicated above. I understand that Florida Cardiac Consultants may utilize a medical record correspondence service and that there may be a fee assessed for that service. I understand that I may revoke this authorization, in writing, at any time, provided that I do so in writing, except to the extent that action has been taken in reliance upon this authorization. Unless revoked earlier, this authorization will expire one year after the date signed. A photocopy or fax of this authorization shall have the same effect as the original.

_____ _____ _____
Signature of Patient or Legal Rep. Relationship to Patient Date

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